UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended March 31, 2010

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____

Commission File Number: 333-71934

VANGUARD
HEALTH SYSTEMS

VANGUARD HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**62-1698183**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

20 Burton Hills Boulevard, Suite 100
Nashville, TN 37215
(Address and zip code of principal executive offices)

(615) 665-6000
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed under Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes☒ No☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of the Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files.) Yes☐ No☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated Filer ☐
Non-accelerated filer ☒	Smaller reporting company☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes☐ No☒

There were 749,104 shares of common stock outstanding as of May 1, 2010 (all of which are privately owned and not traded on a public market).

VANGUARD HEALTH SYSTEMS, INC.
QUARTERLY REPORT ON FORM 10-Q
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PART I
FINANCIAL INFORMATION

Item 1. Financial Statements.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(Unaudited)

	June 30, 2009	March 31, 2010
	(In millions, except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 308.2	$ 210.3
Restricted cash	1.9	2.0
Accounts receivable, net of allowance for doubtful accounts of approximately $121.5 and $70.4 at June 30, 2009 and March 31, 2010, respectively	275.3	294.8
Inventories	48.3	49.2
Deferred tax assets	29.6	18.3
Prepaid expenses and other current assets	68.4	56.4
Total current assets	731.7	631.0
Property, plant and equipment, net of accumulated depreciation	1,174.1	1,173.4
Goodwill	692.1	649.1
Intangible assets, net of accumulated amortization	54.6	68.9
Deferred tax assets, noncurrent	38.0	63.7
Investments in auction rate securities	21.6	21.6
Other assets	19.0	20.0
Total assets	$ 2,731.1	$ 2,627.7
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 127.9	$ 168.2
Accrued salaries and benefits	133.9	125.0
Accrued health plan claims	117.6	141.7
Accrued interest	13.2	17.7
Other accrued expenses and current liabilities	79.5	63.6
Current maturities of long-term debt	8.0	8.2
Total current liabilities	480.1	524.4
Professional and general liability and workers compensation reserves	76.7	79.1
Other liabilities	34.9	30.1
Long-term debt, less current maturities	1,543.6	1,743.4
Commitments and contingencies		
Equity:		
Vanguard Health Systems, Inc. stockholders' equity:		
Common Stock of $.01 par value; 1,000,000 shares authorized; 749,550 and 749,104 issued and outstanding, respectively	–	–
Additional paid-in capital	651.3	354.2
Accumulated other comprehensive loss	(6.8)	(2.5)
Retained deficit	(56.7)	(108.7)
Total Vanguard Health Systems, Inc. stockholders' equity	587.8	243.0
Non-controlling interests	8.0	7.7
Total equity	595.8	250.7
Total liabilities and equity	$ 2,731.1	$ 2,627.7

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(Unaudited)

	Three months ended March 31,		Nine months ended March 31,	
	2009 (as adjusted, See Note 2)	2010	2009 (as adjusted, See Note 2)	2010
	(In millions)			
Patient service revenues	$ 676.1	$ 649.8	$ 1,888.8	$ 1,900.2
Premium revenues	181.9	211.4	480.8	628.0
Total revenues	858.0	861.2	2,369.6	2,528.2
Costs and Expenses:				
Salaries and benefits (includes stock compensation of $1.2, $0.6, $3.4 and $3.5, respectively)	328.4	328.7	923.7	967.6
Health plan claims expense	143.0	168.1	370.7	499.9
Supplies	115.3	114.1	339.9	339.9
Provision for doubtful accounts	52.5	40.7	155.4	112.9
Purchased services	43.3	45.4	125.0	137.7
Non-income taxes	20.7	13.9	39.7	38.8
Rents and leases	11.0	11.2	32.5	33.5
Other operating expenses	58.8	49.6	158.2	158.8
Depreciation and amortization	31.6	34.6	96.0	102.9
Interest, net	27.2	29.9	84.5	84.6
Impairment loss	–	–	–	43.1
Debt extinguishment costs	–	73.2	–	73.2
Other	1.2	0.9	2.0	3.5
Income (loss) from continuing operations before income taxes	25.0	(49.1)	42.0	(68.2)
Income tax benefit (expense)	(8.2)	16.5	(13.5)	18.2
Income (loss) from continuing operations	16.8	(32.6)	28.5	(50.0)
Income (loss) from discontinued operations, net of taxes	(0.3)	0.2	0.6	0.1
Net income (loss)	16.5	(32.4)	29.1	(49.9)
Less: Net income attributable to non-controlling interests	(0.7)	(0.4)	(2.3)	(2.1)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 15.8	$ (32.8)	$ 26.8	$ (52.0)
Amounts attributable to Vanguard Health Systems, Inc. stockholders:				
Income (loss) from continuing operations, net of taxes	$ 16.1	$ (33.0)	$ 26.2	$ (52.1)
Income (loss) from discontinued operations, net of taxes	(0.3)	0.2	0.6	0.1
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 15.8	$ (32.8)	$ 26.8	$ (52.0)

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATED STATEMENT OF EQUITY
Nine months ended March 31, 2010
(Unaudited)

	Vanguard Health Systems, Inc. Stockholders						
	Common Stock						
	Shares	Amount	Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Retained Deficit	Non-Controlling Interests	Total Equity
	(In millions, except share amounts)						
Balance at June 30, 2009	749,550	$ –	$ 651.3	$ (6.8)	$ (56.7)	$ 8.0	$ 595.8
Stock compensation (non-cash)	–	–	3.5	–	–	–	3.5
Repurchase of stock	(242,659)	–	(300.6)	–	–	–	(300.6)
Stock split ($.01 par value)	242,213	–	–	–	–	–	–
Distributions paid to non-controlling interests	–	–	–	–	–	(2.4)	(2.4)
Comprehensive income (loss):							
Change in fair value of interest rate swap (net of tax effect)	–	–	–	2.6	–	–	2.6
Termination of interest rate swap	–	–	–	1.7	–	–	1.7
Net income (loss)	–	–	–	–	(52.0)	2.1	(49.9)
Total comprehensive income (loss)				4.3	(52.0)	2.1	(45.6)
Balance at March 31, 2010	749,104	$ –	$ 354.2	$ (2.5)	$ (108.7)	$ 7.7	$ 250.7

See accompanying notes.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited)

	Nine months ended March 31, 2009 (as adjusted, See Note 2)	Nine months ended March 31, 2010
	(In millions)	
Operating activities:		
Net income (loss)	$ 29.1	$ (49.9)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:		
Income from discontinued operations, net of taxes	(0.6)	(0.1)
Depreciation and amortization	96.0	102.9
Provision for doubtful accounts	155.4	112.9
Deferred income taxes	(1.0)	(20.0)
Amortization of loan costs	4.0	4.1
Accretion of principal on notes	16.0	6.1
Debt extinguishment costs	–	73.2
Loss (gain) on sale of assets	(2.1)	0.5
Stock compensation	3.4	3.5
Non-cash realized holding loss on investments	0.6	–
Impairment loss	–	43.1
Changes in operating assets and liabilities:		
Accounts receivable	(174.5)	(132.4)
Inventories	(0.3)	(0.9)
Prepaid expenses and other current assets	5.4	(12.8)
Accounts payable	15.0	40.2
Accrued expenses and other liabilities	104.4	48.2
Net cash provided by operating activities – continuing operations	250.8	218.6
Net cash provided by operating activities – discontinued operations	0.6	0.1
Net cash provided by operating activities	251.4	218.7
Investing activities:		
Capital expenditures	(87.3)	(111.1)
Acquisitions	(3.7)	(1.5)
Proceeds from asset dispositions	4.0	1.5
Other	(4.3)	(0.3)
Net cash used in investing activities	(91.3)	(111.4)
Financing activities:		
Payments of long-term debt	(5.8)	(1,557.4)
Proceeds from debt borrowings	–	1,751.3
Payments of refinancing costs and fees	–	(90.1)
Repurchases of stock	–	(300.6)
Payments related to derivative instrument with financing element	–	(6.0)
Payments to retire stock and stock options	(0.2)	–
Distributions paid to non-controlling interests	(3.5)	(2.4)
Net cash used in financing activities	(9.5)	(205.2)
Net increase (decrease) in cash and cash equivalents	150.6	(97.9)
Cash and cash equivalents, beginning of period	141.6	308.2
Cash and cash equivalents, end of period	$ 292.2	$ 210.3
Net cash paid for interest	$ 53.1	$ 72.7
Net cash paid (received) for income taxes	$ 4.2	$ (13.2)

See accompanying notes.

1. BUSINESS AND BASIS OF PRESENTATION

Business

Vanguard Health Systems, Inc. ("Vanguard") is an investor-owned healthcare company whose affiliates own and operate hospitals and related healthcare businesses in urban and suburban areas. As of March 31, 2010, Vanguard's affiliates owned and managed 15 acute care hospitals with 4,135 licensed beds and related outpatient service locations complementary to the hospitals providing healthcare services in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts. Vanguard also owns three managed health plans in Chicago, Illinois and Phoenix, Arizona and two surgery centers in Orange County, California.

Basis of Presentation

The accompanying unaudited condensed consolidated financial statements include the accounts of subsidiaries and affiliates controlled by Vanguard. Vanguard generally defines control as the ownership of the majority of an entity's voting interests. Vanguard also consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All material intercompany accounts and transactions have been eliminated. Since none of Vanguard's common shares are publicly held, no earnings per share information is presented in the accompanying unaudited condensed consolidated financial statements. Certain prior year amounts from the accompanying condensed consolidated financial statements have been reclassified to conform to current year presentation. The majority of Vanguard's expenses are "cost of revenue" items. Costs that could be classified as general and administrative include certain Vanguard corporate office costs, which approximated $13.6 million, $17.1 million, $37.1 million and $51.0 million for the three and nine months ended March 31, 2009 and 2010, respectively.

During the first quarter of fiscal 2010, Vanguard implemented its new uninsured discount policy in its Phoenix and San Antonio hospitals similar to the policy adopted at its Illinois hospitals in April 2009. The new policy applies to patients receiving services in these hospitals who had no insurance coverage and who did not otherwise qualify for charity care under Vanguard's guidelines. Under this policy, Vanguard applies an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and includes this discount as a reduction to patient service revenues. Total uninsured discounts were approximately $48.1 million and $161.0 million for the three months and nine months ended March 31, 2010, respectively.

The unaudited condensed consolidated financial statements as of March 31, 2010 and for the three and nine months ended March 31, 2009, as adjusted (see Note 2), and 2010 have been prepared in conformity with accounting principles generally accepted in the United States for interim reporting and in accordance with Rule 10-01 of Regulation S-X. Accordingly, they do not include all of the information and notes required by accounting principles generally accepted in the United States for complete financial statements. In the opinion of management, the unaudited condensed consolidated financial statements reflect all adjustments (consisting of normal recurring adjustments) necessary for a fair presentation of the financial position and the results of operations for the periods presented. The results of operations for the periods presented are not necessarily indicative of the expected results for the fiscal year ending June 30, 2010. The interim unaudited condensed consolidated financial statements should be read in connection with the audited consolidated financial statements as of and for the year ended June 30, 2009 included in Vanguard's Current Report on Form 8-K filed with the Securities and Exchange Commission on January 19, 2010.

Use of Estimates

In preparing Vanguard's financial statements in conformity with accounting principles generally accepted in the United States, management makes estimates and assumptions that affect the amounts recorded or classification of items in the unaudited condensed consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Refinancing Transactions

In January 2010, Vanguard completed a comprehensive refinancing plan (the "Refinancing"). Under the Refinancing, certain of Vanguard's subsidiaries issued $950.0 million of new 8.0% Senior Unsecured Notes due 2018 (the "8.0% Notes"), entered into an $815.0 million senior secured term loan maturing in 2016 (the "2010 term loan facility") and entered into a new $260.0 million revolving credit facility that expires in 2015 (the "2010 revolving facility"). The proceeds from these new debt instruments were used to repay the outstanding principal and interest related to Vanguard's previous term loan facility; to retire its previously outstanding 9.0% senior subordinated notes (the "9.0% Notes") and its 11.25% senior discount notes (the "11.25% Notes") through redemption or tender offers/consent solicitations and pay accrued interest for such notes; to purchase 446 shares of common stock from certain former employees; to fund a $300.0 million distribution to repurchase a portion of the shares owned by the remaining stockholders; and to pay fees and expenses relating to the Refinancing of $90.1 million. See Notes 7 and 10 for additional discussion of the debt and equity transactions associated with the Refinancing.

2. ADOPTION OF NEW ACCOUNTING STANDARDS

In June 2009, the Financial Accounting Standards Board ("FASB") issued its Accounting Standards Codification ("ASC") and modified the Generally Accepted Accounting Principles ("GAAP") hierarchy by establishing only two levels of GAAP, authoritative and nonauthoritative accounting literature. Effective July 2009, ASC is considered the single source of authoritative U.S. accounting and reporting standards, except for additional authoritative rules and interpretive releases issued by the SEC. Nonauthoritative guidance and literature would include, among other things, FASB Concepts Statements, American Institute of Certified Public Accountants Issue Papers and Technical Practice Aids and accounting textbooks. ASC was developed to organize GAAP pronouncements by topic so that users can more easily access authoritative accounting guidance. It is organized by topic, subtopic, section, and paragraph, each of which is identified by a numerical designation. This guidance became effective for Vanguard beginning in the first quarter of its fiscal year ending June 30, 2010.

Effective July 1, 2009, Vanguard adopted the transition guidance of accounting for non-controlling interests in consolidated financial statements. The guidance establishes a single method of accounting for non-controlling interests in subsidiaries and requires non-controlling interests in a subsidiary to be reported as a component of equity in the consolidated balance sheet subject to the guidance for distinguishing liabilities from equity. The transition guidance also requires consolidated net income (loss) to include both the parent and non-controlling interest's portion of the operating results of the subsidiary with separate disclosure on the income statement of the amounts attributable to the parent versus the non-controlling interest. The following describes the impact to Vanguard's financial statements as of June 30, 2009 and March 31, 2010 and for the three and nine months ended March 31, 2009 and 2010 related to the adoption of this guidance (the presentation and disclosure requirements of the guidance discussed above were retrospectively applied in Vanguard's Current Report on Form 8-K filed with the Securities and Exchange Commission on January 19, 2010 to certain financial statements of Vanguard as of and for the periods prior to adoption).

- Vanguard reclassified its minority interests in equity of consolidated entities from the liabilities section of its balance sheets to equity. This reclassification was $8.0 million as of June 30, 2009. Vanguard has one non-controlling interest whose classification was included in mezzanine equity due to the existence of redemption features that are outside the control of Vanguard. However, the fair value of this non-controlling interest was zero (the maximum redemption value) as of June 30, 2009 and March 31, 2010.

- Net income attributable to non-controlling interests is no longer deducted to arrive at net income (loss). Instead, net income (loss) is attributed to the controlling and non-controlling interests in the condensed consolidated statements of operations. Accordingly, net income increased by $0.7 million and $2.3, respectively, million for the three and nine months ended March 31, 2009 compared to net income previously reported for those periods.

- The payment of cash distributions to the entities holding the non-controlling interests are now reported as financing activities on the condensed consolidated statements of cash flows for the nine months ended March 31, 2009 and 2010 instead of being included in operating activities. These cash distributions were $3.5 million and $2.4 million for the nine months ended March 31, 2009 and 2010, respectively.

3. FAIR VALUE MEASUREMENTS

Fair value is determined using assumptions that market participants would use to determine the price of the asset or liability as opposed to measurements determined based upon information specific to the entity holding those assets and liabilities. To determine those market participant assumptions, Vanguard considered the guidance for fair value measurements and disclosures, the hierarchy of inputs that the entity must consider including both independent market data inputs and the entity's own assumptions about the market participant assumptions. This hierarchy is summarized as follows.

Level 1 Unadjusted quoted prices in active markets for identical assets and liabilities.

Level 2 Directly or indirectly observable inputs, other than quoted prices included in Level 1. Level 2 inputs may include, among others, interest rates and yield curves observable at commonly quoted intervals, volatilities, loss severities, credit risks and other inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3 Unobservable inputs used when there is little, if any, market activity for the asset or liability at the measurement date. These inputs represent the entity's own assumptions about the assumptions that market participants would use to price the asset or liability developed using the best information available.

Vanguard's policy is to recognize transfers between levels as of the actual date of the event, or change in circumstances, that caused the transfer.

The following table summarizes Vanguard's assets measured at fair value on a recurring basis as of March 31, 2010, aggregated by the fair value hierarchy level within which those measurements were made (in millions).

	Fair Value	Level 1 Inputs	Level 2 Inputs	Level 3 Inputs
Assets:				
Investments in auction rate securities	$ 21.6	$ –	$ –	$ 21.6

There was no significant change in the fair value measurements using significant Level 3 unobservable inputs from June 30, 2009 to March 31, 2010.

Auction Rate Securities

At March 31, 2010, Vanguard held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in investments in auction rate securities on the accompanying condensed consolidated balance sheets. These ARS are accounted for as long-term available for sale securities. The par value of the ARS was $26.3 million at March 31, 2010. The ARS have maturity dates ranging from 2039 to 2043 and are guaranteed by the U.S. government at approximately 96%-98% of the principal and accrued interest under the Federal Family Education Loan Program or other similar programs. Due to the lack of market liquidity and other observable market inputs for these ARS, Vanguard utilized Level 3 inputs to estimate the $21.6 million fair value of these ARS. Valuations from forced liquidations or distressed sales are inconsistent with the definition of fair value set forth in the pertinent accounting guidance, which assumes an orderly market. For its valuation estimate, management utilized a discounted cash flow analysis that included estimates of the timing of liquidation of these ARS and the impact of market risks on exit value. Vanguard does not currently intend to sell and does not believe it is more likely than not it will be required to sell these ARS prior to liquidity returning to the market and their fair value recovering to par value.

In September 2008, Vanguard received a tender offer for $10.0 million par value of ARS at 94% of par value. As a result of Vanguard's acceptance of the tender offer and the other-than-temporary decline in fair value, Vanguard recorded a $0.6 million realized holding loss on these marketable securities during the quarter ended September 30, 2008, which is included in other expenses on the accompanying condensed consolidated statement of operations for the nine months ended March 31, 2009. However, the tender offer contained certain conditions that were not met as of the December 2008 deadline, and the tender failed. As a result of the failed tender and continued lack of immediate marketability, all $21.6 million of ARS are presented as long-term assets on the accompanying condensed consolidated balance sheets. In addition, Vanguard recorded

temporary impairments of $4.1 million ($2.5 million, net of taxes) related to the ARS during the fiscal year ended June 30, 2009, which are included in accumulated other comprehensive loss ("AOCL") on the condensed consolidated balance sheets.

Cash and Cash Equivalents and Restricted Cash

The carrying amounts reported for cash and cash equivalents and restricted cash approximate fair value because of the short-term maturity of these instruments.

Accounts Receivable and Accounts Payable

The carrying amounts reported for accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

Long-Term Debt

The fair values of the 8.0% Notes and the 2010 term loan facility as of March 31, 2010 were approximately $926.3 million and $821.1 million, respectively, based upon stated market prices. The fair values are subject to change as market conditions change.

4. STOCK-BASED COMPENSATION

Vanguard has one stock-based compensation plan, the 2004 Stock Incentive Plan ("the 2004 Option Plan"). As of March 31, 2010, the 2004 Option Plan, as amended, allows for the issuance of up to 145,611 options to purchase common stock of Vanguard to its employees. The stock options may be granted as Liquidity Event Options, Time Options or Performance Options at the discretion of the Board. The Liquidity Event Options vest 100% at the eighth anniversary of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Time Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price per share as determined by the Board or a committee thereof. The Performance Options vest 20% at each of the first five anniversaries of the date of grant and have an exercise price equal to $2,599.53 per share or as determined by the Board or a committee thereof. The Time Options and Performance Options immediately vest upon a change of control, while the Liquidity Event Options immediately vest only upon a qualifying Liquidity Event, as defined in the 2004 Option Plan. As of March 31, 2010, 113,919 options were outstanding under the 2004 Option Plan. Vanguard recognized compensation expense related to the 2004 Option Plan of $1.2 million, $0.6 million, $3.4 million and $3.5 million during the three and nine months ended March 31, 2009 and 2010, respectively. See Note 10 for additional information related to the 2004 Option Plan resulting from the Refinancing.

5. INTANGIBLE ASSETS

The following table provides information regarding the intangible assets, including deferred loan costs, included on the accompanying condensed consolidated balance sheets as of June 30, 2009 and March 31, 2010 (in millions).

	Gross Carrying Amount		Accumulated Amortization	
Class of Intangible Asset	June 30, 2009	March 31, 2010	June 30, 2009	March 31, 2010
Amortized intangible assets:				
Deferred loan costs	$ 43.8	$ 37.9	$ 21.5	$ 0.7
Contracts	31.4	31.4	14.9	17.3
Physician income and other guarantees	27.2	30.5	18.3	22.0
Other	4.7	8.3	1.0	2.4
Subtotal	107.1	108.1	55.7	42.4
Indefinite-lived intangible assets:				
License and accreditation	3.2	3.2	–	–
Total	$ 110.3	$ 111.3	$ 55.7	$ 42.4

Amortization expense for contract-based intangibles and other intangible assets during the nine months ended March 31, 2009 and 2010 was approximately $2.7 million and $3.8 million, respectively.

Amortization of deferred loan costs of $4.0 million and $4.1 million during the nine months ended March 31, 2009 and 2010, respectively, is included in net interest. In connection with the Refinancing (Note 1) approximately $18.5 million of the previously capitalized deferred loan costs were expensed as debt extinguishment costs and approximately $0.6 million will continue to be amortized under carryover lender provisions. In addition, Vanguard capitalized approximately $37.3 million of deferred loan costs during the three months ended March 31, 2010 associated with its new debt instruments.

Amortization of physician income and other guarantees of $4.5 million and $3.7 million during the nine months ended March 31, 2009 and 2010, respectively, is included in purchased services or other operating expenses.

6. IMPAIRMENT OF GOODWILL AND LONG-LIVED ASSETS

Vanguard's two Chicago hospitals have experienced deteriorating economic factors that have negatively impacted their results of operations and cash flows. While various initiatives mitigated the impact of these economic factors during fiscal years 2008 and 2009, the operating results of the Chicago hospitals did not improve to the level anticipated during the first half of fiscal 2010. After having the opportunity to evaluate the operating results of the Chicago hospitals for the first six months of fiscal year 2010 and reassess the market trends and economic factors, Vanguard concluded that it was unlikely that previously projected cash flows for these hospitals would be achieved. Vanguard performed an interim goodwill impairment test during the quarter ended December 31, 2009 and, based upon revised projected cash flows, market participant data and appraisal information, Vanguard determined that the $43.1 million remaining goodwill related to this reporting unit of Vanguard's acute care services segment was impaired. Vanguard recorded a $43.1 million ($31.8 million, net of taxes) non-cash impairment loss in the condensed consolidated statement of operations during the nine months ended March 31, 2010.

7. FINANCING ARRANGEMENTS

A summary of Vanguard's long-term debt at June 30, 2009 and March 31, 2010 follows (in millions).

	June 30, 2009	March 31, 2010
9.0% Senior Subordinated Notes	$ 575.0	$ –
11.25% Senior Discount Notes	210.2	–
Term loans payable under credit facility due 2011	766.4	–
8.0% Senior Unsecured Notes	–	936.6
Term loans payable under credit facility due 2016	–	815.0
	1,551.6	1,751.6
Less: current maturities	(8.0)	(8.2)
	$ 1,543.6	$ 1,743.4

8.0% Notes

In connection with the Refinancing on January 29, 2010, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Issuers"), completed a private placement of $950.0 million ($936.3 million cash proceeds) 8% Senior Unsecured Notes due February 1, 2018 ("8.0% Notes"). Interest on the 8.0% Notes is payable semi-annually on August 1 and February 1 of each year. The 8.0% Notes are unsecured general obligations of the Issuers and rank *pari passu* in right of payment to all existing and future senior unsecured indebtedness of the Issuers. The $13.7 million discount is accreted to par over the term of the 8.0% Notes. All payments on the 8.0% Notes are guaranteed jointly and severally on a senior unsecured basis by Vanguard and its domestic

subsidiaries, other than those subsidiaries that do not guarantee the obligations of the borrowers under the senior credit facilities.

On or after February 1, 2014, the Issuers may redeem all or part of the 8.0% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 8.0% Notes. In addition, the Issuers may redeem up to 35% of the 8.0% Notes prior to February 1, 2013 with the net cash proceeds from certain equity offerings at a price equal to 108% of their principal amount, plus accrued and unpaid interest. The Issuers may also redeem some or all of the 8.0% Notes before February 1, 2014 at a redemption price equal to 100% of the principal amount thereof, plus a "make-whole" premium and accrued and unpaid interest.

On May 7, 2010, the Issuers exchanged substantially all of their outstanding 8.0% Notes for new 8.0% senior unsecured notes with identical terms and conditions, except that the exchange notes were registered under the Securities Act of 1933. Terms and conditions of the exchange offer were set forth in the registration statement on Form S-4 filed with the Securities and Exchange Commission on March 3, 2010, that became effective on April 1, 2010.

Credit Facility Debt

In connection with the Refinancing on January 29, 2010, two of Vanguard's wholly owned subsidiaries, Vanguard Health Holding Company II, LLC and Vanguard Holding Company II, Inc. (collectively, the "Co-borrowers"), entered into new senior secured credit facilities (the "2010 credit facilities") with various lenders and Bank of America, N.A. and Barclays Capital as joint book runners, and repaid all amounts outstanding under the previous credit facility. The 2010 credit facilities include a six-year term loan facility (the "2010 term loan facility") in the aggregate principal amount of $815.0 million and a five-year $260.0 million revolving credit facility (the "2010 revolving facility").

In addition, subject to the receipt of commitments by existing lenders or other financial institutions and the satisfaction of certain other conditions, the Co-borrowers may request an incremental term loan facility to be added to the 2010 term loan facility. The Co-borrowers may seek to increase the borrowing availability under the 2010 revolving facility to an amount larger than $260.0 million, subject to the receipt of commitments by existing lenders or other financial institutions for such increased revolving capacity and the satisfaction of other conditions. Vanguard's remaining borrowing capacity under the 2010 revolving facility, net of letters of credit outstanding, was $229.8 million as of March 31, 2010.

The 2010 term loan facility bears interest at a rate equal to, at Vanguard's option, LIBOR (subject to a 1.50% floor) plus 3.50% per annum or a base rate plus 2.50% per annum. The interest rate applicable to Vanguard's term loan facility borrowings was approximately 5.0% as of March 31, 2010. Vanguard also makes quarterly principal payments equal to one-fourth of one percent of the outstanding principal balance of the 2010 term loan facility and will continue to make such payments until maturity of the term debt.

Any future borrowings under the 2010 revolving facility will bear interest at a rate equal to, at Vanguard's option, LIBOR plus 3.50% per annum or a base rate plus 2.50% per annum, both of which are subject to a decrease of up to 0.25% dependent upon Vanguard's consolidated leverage ratio. Vanguard may utilize the 2010 revolving facility to issue up to $100.0 million of letters of credit ($30.2 million of which were outstanding at March 31, 2010). Vanguard also pays a commitment fee to the lenders under the 2010 revolving facility in respect of unutilized commitments thereunder at a rate equal to 0.50% per annum. Vanguard also pays customary letter of credit fees under this facility. The 2010 credit facilities contain numerous covenants that restrict Vanguard or its subsidiaries from completing certain transactions and also include limitations on capital expenditures, a minimum interest coverage ratio requirement and a maximum leverage ratio requirement. Vanguard's first test period to comply with these covenants is June 30, 2010.

Obligations under the credit agreement governing the 2010 term loan facility are unconditionally guaranteed by Vanguard and Vanguard Health Holding Company I, LLC ("VHS Holdco I") and, subject to certain exceptions, each of VHS Holdco I's wholly-owned domestic subsidiaries (the "U.S. Guarantors"). Obligations under this credit agreement are also secured by substantially all of the assets of Vanguard Health Holding Company II, LLC ("VHS Holdco II") and the U.S. Guarantors including a pledge of 100% of the membership interests of VHS Holdco II, 100% of the capital stock of substantially all U.S. Guarantors (other than VHS Holdco I) and 65% of the capital stock of each of VHS Holdco II's non-U.S. subsidiaries that are directly owned by VHS Holdco II or one of the U.S. Guarantors and a security interest in substantially all tangible and intangible assets of VHS Holdco II and each U.S. Guarantor.

Maturities

The aggregate annual principal payments of long-term debt for the remainder of fiscal 2010 and each fiscal year thereafter are as follows: 2010 - $2.0 million; 2011 - $8.1 million; 2012 - $8.1 million; 2013 - $8.1 million; 2014 -$8.1 million; 2015 - $8.1 million and $1,722.5 million thereafter.

Debt Extinguishment Costs

In connection with the Refinancing, Vanguard recorded debt extinguishment costs of $73.2 million ($45.4 million net of taxes). The debt extinguishment costs include $40.2 million of tender/consent fees and call premiums to extinguish the 9.0% Notes and 11.25% Notes, $18.5 million of previously capitalized loan costs, $11.8 million of loan costs incurred related to the new debt instruments that Vanguard expensed in accordance with accounting guidance related to modifications or exchanges of debt instruments for which carryover lenders' cash flows changed by more than 10%, $1.7 million for the interest rate swap settlement payment and $1.0 million of third party costs, all related to the Refinancing.

8. INCOME TAXES

Significant components of the provision for income taxes from continuing operations are as follows (in millions).

	Nine months ended	
	March 31, 2009	March 31, 2010
Current:		
Federal	$ 12.8	$ 0.4
State	1.7	1.4
Total current	14.5	1.8
Deferred:		
Federal	1.8	(20.5)
State	(2.4)	(2.9)
Total deferred	(0.6)	(23.4)
Change in valuation allowance	(0.4)	3.4
Total income tax expense (benefit)	$ 13.5	$ (18.2)

The effective income tax rate differed from the federal statutory rate for the periods presented as follows:

	Nine months ended	
	March 31, 2009	March 31, 2010
Income tax at federal statutory rate	35.0%	35.0%
Income tax at state statutory rate	(3.2)	2.8
Nondeductible expenses and other	3.3	(1.1)
Book income of consolidated partnerships attributable to noncontrolling interests	(1.9)	1.1
Nondeductible impairment loss	–	(6.1)
Change in valuation allowance	(1.0)	(5.0)
Effective income tax rate	32.2%	26.7%

As of March 31, 2010, Vanguard had generated net operating loss ("NOL") carryforwards for federal income tax and state income tax purposes of approximately $209.0 million and $700.0 million, respectively. The remaining federal and state NOL carryforwards expire from 2029 to 2031 and 2010 to 2031, respectively.

Vanguard's U.S. federal income tax returns for tax years 2005 and subsequent years remain subject to examination by the Internal Revenue Service.

9. COMPREHENSIVE INCOME (LOSS)

Comprehensive income (loss) consists of two components: net income (loss) and other comprehensive income (loss). Other comprehensive income (loss) refers to revenues, expenses, gains and losses that under the relative accounting guidance are recorded as elements of equity but are excluded from net income (loss). The following table presents the components of comprehensive income (loss), net of taxes, for the three and nine month periods ended March, 2009 and 2010 (in millions).

	Three months ended March 31, 2009	Three months ended March 31, 2010	Nine months ended March 31, 2009	Nine months ended March 31, 2010
Net income (loss)	$ 16.5	$ (32.4)	$ 29.1	$ (49.9)
Change in fair value of interest rate swap	0.2	0.9	(12.9)	5.2
Change in unrealized holding losses on auction rate securities	–	–	(1.5)	–
Change in income tax (expense) benefit	–	(1.0)	5.6	(2.6)
Termination of interest rate swap	–	1.7	–	1.7
Comprehensive income (loss)	$ 16.7	$ (30.8)	$ 20.3	$ (45.6)

The reclassification adjustments from accumulated other comprehensive loss to net loss, for the interest rate swap termination were $1.7 million ($1.0 million net of taxes) and are included in debt extinguishment costs for the three months and nine months ended March 31, 2010.

The components of accumulated other comprehensive loss, net of taxes, as of June 30, 2009 and March 31, 2010 are as follows (in millions).

	June 30, 2009	March 31, 2010
Fair value of interest rate swap	$ (6.9)	$ –
Unrealized holding loss on investments in auction rate securities	(4.1)	(4.1)
Income tax benefit	4.2	1.6
Accumulated other comprehensive loss	$ (6.8)	$ (2.5)

10. EQUITY TRANSACTIONS

In January 2010, Vanguard's Board of Directors authorized and Vanguard completed the repurchase of 446 shares held by certain former employees and 242,213 shares of outstanding common stock held by the remaining shareholders through privately negotiated transactions for $300.6 million as part of the Refinancing. Subsequent to the $300.6 million share repurchase, Vanguard completed a 1.4778 for one split that effectively returned the share ownership for each stockholder that participated in the distribution (other than the holders of the 446 shares) to the same level as that in effect immediately prior to the distribution. As required by the 2004 Option Plan, Vanguard reduced the exercise price for each class of outstanding options by $400.47, the per share equivalent of the repurchase of 242,213 shares discussed above, in order to keep the potential ownership position of the option holders equitable subsequent to such share repurchases and common share stock split. The exercise price adjustment did not result in additional stock compensation expense during the current period.

11. RECENTLY ISSUED ACCOUNTING PRONOUNCEMENTS

In January 2010, the FASB issued Accounting Standard Update ("ASU") 2010-06, an amendment to ASC 820-10, "Fair Value Measurements and Disclosures—Overall," that requires additional disclosures about the different classes of assets and liabilities measured at fair value, the valuation techniques and inputs used, the activity in Level 3 fair value measurements and the transfers between Levels 1, 2 and 3. The new disclosures and clarifications of existing disclosures were effective for Vanguard's quarter ended March 31, 2010, except for the disclosures about the roll-forward of activity in Level 3 fair value measurements, which will be required to be adopted by Vanguard for the quarter ended September 30, 2011. The adoption of this standard will have no significant impact on Vanguard's financial position, results of operations or cash flows.

In September 2009, the FASB issued additional guidance concerning the manner in which fair value of liabilities should be determined. Previous guidance defined the fair value of a liability as the price that would be paid to transfer the liability in an orderly transaction between market participants at the measurement date. The new guidance amends these criteria by specifically addressing valuation techniques, liabilities traded as assets and quoted prices in an active market. The new guidance was effective for Vanguard's quarter ended March 31, 2010. The adoption of this new guidance did not significantly impact Vanguard's financial position, results of operations or cash flows.

12. SEGMENT INFORMATION

Vanguard's acute care hospitals and related healthcare businesses are similar in their activities and the economic environments in which they operate (i.e. urban markets). Accordingly, Vanguard's reportable operating segments consist of 1) acute care hospitals and related healthcare businesses, collectively, and 2) health plans consisting of MacNeal Health Providers, a contracting entity for outpatient services provided by MacNeal Hospital and Weiss Memorial Hospital and participating physicians in the Chicago area, Phoenix Health Plan, a Medicaid managed health plan operating in Arizona, and Abrazo Advantage Health Plan, a Medicare and Medicaid dual eligible managed health plan operating in Arizona.

The following tables provide unaudited condensed financial information by operating segment for the three and nine month periods ended March 31, 2009 and 2010, including a reconciliation of Segment EBITDA to income (loss) from continuing operations before income taxes (in millions).

	Three months ended March 31, 2009				Three months ended March 31, 2010			
	Acute Care Services	Health Plans	Eliminations	Consolidated	Acute Care Services	Health Plans	Eliminations	Consolidated
Patient service revenues (1)	$ 676.1	$ –	$ –	$ 676.1	$ 649.8	$ –	$ –	$ 649.8
Premium revenues	–	181.9	–	181.9	–	211.4	–	211.4
Inter-segment revenues	7.7	–	(7.7)	–	10.7	–	(10.7)	–
Total revenues	683.8	181.9	(7.7)	858.0	660.5	211.4	(10.7)	861.2
Salaries and benefits (excludes stock compensation)	319.0	8.2	–	327.2	319.7	8.4	–	328.1
Health plan claims expense (1)	–	143.0	–	143.0	–	168.1	–	168.1
Supplies	115.3	–	–	115.3	114.1	–	–	114.1
Provision for doubtful accounts	52.5	–	–	52.5	40.7	–	–	40.7
Other operating expenses - external	124.3	9.5	–	133.8	110.8	9.3	–	120.1
Operating expenses – inter-segment	–	7.7	(7.7)	–	–	10.7	(10.7)	–
Total operating expenses	611.1	168.4	(7.7)	771.8	585.3	196.5	(10.7)	771.1
Segment EBITDA (2)	72.7	13.5	–	86.2	75.2	14.9	–	90.1
Less:								
Interest, net	26.9	0.3	–	27.2	30.1	(0.2)	–	29.9
Depreciation and amortization	30.6	1.0	–	31.6	33.5	1.1	–	34.6
Equity method income	(0.1)	–	–	(0.1)	(0.3)	–	–	(0.3)
Stock compensation	1.2	–	–	1.2	0.6	–	–	0.6
Monitoring fees and expenses	1.3	–	–	1.3	1.2	–	–	1.2
Debt extinguishment costs	–	–	–	–	73.2	–	–	73.2
Income (loss) from continuing operations before income taxes	$ 12.8	$ 12.2	$ –	$ 25.0	$ (63.1)	$ 14.0	$ –	$ (49.1)
Capital expenditures	$ 32.3	$ 0.3	$ –	$ 32.6	$ 42.6	$ 0.1	$ –	$ 42.7

	Nine months ended March 31, 2009				Nine months ended March 31, 2010			
	Acute Care Services	Health Plans	Eliminations	Consolidated	Acute Care Services	Health Plans	Eliminations	Consolidated
Patient service revenues (1)	$ 1,888.8	$ –	$ –	$ 1,888.8	$ 1,900.2	$ –	$ –	$ 1,900.2
Premium revenues	–	480.8	–	480.8	–	628.0	–	628.0
Inter-segment revenues	25.0	–	(25.0)	–	31.7	–	(31.7)	–
Total revenues	1,913.8	480.8	(25.0)	2,369.6	1,931.9	628.0	(31.7)	2,528.2
Salaries and benefits (excludes stock compensation)	897.6	22.7	–	920.3	938.9	25.2	–	964.1
Health plan claims expense (1)	–	370.7	–	370.7	–	499.9	–	499.9
Supplies	339.7	0.2	–	339.9	339.8	0.1	–	339.9
Provision for doubtful accounts	155.4	–	–	155.4	112.9	–	–	112.9
Other operating expenses - external	328.6	26.8	–	355.4	341.6	27.2	–	368.8
Operating expenses – inter-segment	–	25.0	(25.0)	–	–	31.7	(31.7)	–
Total operating expenses	1,721.3	445.4	(25.0)	2,141.7	1,733.2	584.1	(31.7)	2,285.6
Segment EBITDA (2)	192.5	35.4	–	227.9	198.7	43.9	–	242.6
Less:								
Interest, net	85.3	(0.8)	–	84.5	85.2	(0.6)	–	84.6
Depreciation and amortization	93.0	3.0	–	96.0	99.6	3.3	–	102.9
Equity method income	(0.4)	–	–	(0.4)	(0.8)	–	–	(0.8)
Stock compensation	3.4	–	–	3.4	3.5	–	–	3.5
Loss (gain) on disposal of assets	(2.1)	–	–	(2.1)	0.4	–	–	0.4
Realized holding loss on investments	0.6	–	–	0.6	–	–	–	–
Monitoring fees and expenses	3.9	–	–	3.9	3.9	–	–	3.9
Debt extinguishment costs	–	–	–	–	73.2	–	–	73.2
Impairment loss	–	–	–	–	43.1	–	–	43.1
Income (loss) from continuing operations before income taxes	$ 8.8	$ 33.2	$ –	$ 42.0	$ (109.4)	$ 41.2	$ –	$ (68.2)
Capital expenditures	$ 85.7	$ 1.6	$ –	$ 87.3	$ 110.5	$ 0.6	$ –	$ 111.1
Segment assets	$ 2,586.5	$ 156.5	$ –	$ 2,743.0	$ 2,474.2	$ 153.5	$ –	$ 2,627.7

(1) Vanguard eliminates in consolidation those patient service revenues earned by its hospitals and related healthcare facilities attributable to services provided to enrollees in its owned health plans and also eliminates the corresponding medical claims expenses incurred by the health plans for those services.

(2) Segment EBITDA is defined as income (loss) from continuing operations before income taxes less interest expense (net of interest income), depreciation and amortization, equity method income, stock compensation, gain or loss on disposal of assets, realized holding losses on investments, monitoring fees and expenses, debt extinguishment costs and impairment losses. Management uses Segment EBITDA to measure performance for Vanguard's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA eliminates the uneven effect of non-cash depreciation of tangible assets and amortization of intangible assets, much of which results from acquisitions accounted for under the purchase method of accounting. Segment EBITDA also eliminates the effects of changes in interest rates which management believes relate to general trends in global capital markets, but are not necessarily indicative of the operating performance of Vanguard's segments. Management believes that Segment EBITDA provides useful information about the financial performance of Vanguard's segments to investors, lenders, financial analysts and rating agencies. Additionally, management believes that investors and lenders view Segment EBITDA as an important factor in making investment decisions and assessing the value of Vanguard. Segment EBITDA is not a substitute for net income (loss), operating cash flows or other cash flow statement data determined in accordance with accounting principles generally accepted in the United States. Segment EBITDA, as presented, may not be comparable to similarly titled measures of other companies.

13. COMMITMENTS AND CONTINGENCIES

Management evaluates contingencies based upon the best available information and believes that adequate provision for potential losses associated with contingencies has been made. In management's opinion, based on current available information, these commitments described below will not have a material effect on Vanguard's results of operations or financial position, but the capital commitments could have an effect on the timing of Vanguard's cash flows, including its need to borrow available amounts under its 2010 revolving facility.

Capital Expenditure Commitments

During the three months ended March 31, 2010, Vanguard entered into a $56.4 million agreement for the construction of a replacement facility for one of its hospitals in San Antonio, Texas. Vanguard expects to spend a total of $86.2 million, including costs to equip, to complete the project and expects the new facility to open in the summer of 2011. Through March 31, 2010, Vanguard had spent approximately $5.0 million, of the total budgeted $86.2 million, related to this replacement facility. Vanguard currently has multiple other capital projects underway including significant advanced clinical system upgrades. As of March 31, 2010, Vanguard estimated its remaining commitments to complete all capital projects in process to be approximately $72.7 million.

Insurance Risks

Given the nature of its operating environment, Vanguard is subject to professional and general liability claims and related lawsuits in the ordinary course of business. For professional and general liability claims incurred from June 1, 2002 to May 31, 2006 and incurred subsequent to June 30, 2009, Vanguard's wholly owned captive subsidiary insured its risks at a $10.0 million retention level. For claims incurred between June 1, 2006 and June 30, 2009, Vanguard self-insures the first $9.0 million per claim, and the captive subsidiary insures the next $1.0 million per claim. Vanguard's captive subsidiary maintains excess coverage from independent third party insurers on a claims-made basis for individual claims exceeding $10.0 million up to $75.0 million, but limited to total annual payments of $65.0 million in the aggregate. Vanguard self-insures its workers compensation claims up to $1.0 million per claim and purchases excess insurance coverage for claims exceeding $1.0 million. During the nine months ended March 31, 2010, Vanguard increased its professional and general liability reserve by $8.4 million ($5.3 million, net of taxes) and reduced its workers compensation reserve by $5.1 ($3.2 million, net of taxes) million for changes in claims development related to prior years. During the quarter ended March 31, 2010, Vanguard settled and paid the significant professional liability case for which a $14.9 million verdict was rendered in April 2009. In connection with this settlement, the previous $20.0 million cash escrow deposit was transferred to Vanguard's operating cash account and a portion used to pay the settlement.

Patient Service Revenues

Settlements under reimbursement agreements with third party payers are estimated during the period the related services are provided, but final settlements are typically not known until future periods. There is at least a reasonable possibility that recorded estimates will change by a material amount when final settlements are known. Differences between original estimates and subsequent revisions (including final settlements) are included in the condensed consolidated statements of operations in the period in which the revisions are made. Management believes that adequate provision has been made for adjustments that may result from final determination of amounts earned under the Medicare and Medicaid programs and other managed care plans with settlement provisions. Net adjustments for final third party settlements positively impacted Vanguard's income (loss) from continuing operations before income taxes by $1.6 million and $1.6 million for the three months ended March 31, 2009 and 2010 and by $5.4 million and $6.1 million for the nine months ended March 31, 2009 and 2010, respectively. Vanguard recorded $21.9 million and $21.0 million of charity care deductions during the three months ended March 31, 2009 and 2010, respectively. Vanguard recorded $70.3 million and $64.2 million of charity care deductions during the nine months ended March 31, 2009 and 2010, respectively.

Governmental Regulation

Laws and regulations governing the Medicare, Medicaid and other federal healthcare programs are complex and subject to interpretation. Vanguard's management believes that it is in compliance with all applicable laws and regulations in all material respects. However, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid

and other federal healthcare programs. Vanguard is not aware of any material regulatory proceeding or investigation underway or threatened involving allegations of potential wrongdoing.

Acquisitions

Vanguard has acquired and will continue to acquire businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, anti-kickback and physician self-referral laws. Although Vanguard institutes policies designed to conform practices to its standards following completion of acquisitions and attempts to structure its acquisitions as asset acquisitions in which Vanguard does not assume liability for seller wrongful actions, there can be no assurance that Vanguard will not become liable for past activities that may later be alleged to be improper by private plaintiffs or government agencies. Although Vanguard obtains general indemnifications from sellers covering such matters, there can be no assurance that any specific matter will be covered by such indemnifications, or if covered, that such indemnifications will be adequate to cover potential losses and fines.

Guarantees

Physician Guarantees

In the normal course of its business, Vanguard enters into physician relocation agreements under which it guarantees minimum monthly income, revenues or collections or guarantees reimbursement of expenses up to maximum limits to physicians during a specified period of time (typically, 12 months to 36 months). In return for the guarantee payments, the physicians are required to practice in the community for a stated period of time (typically, 3 to 4 years) or else return the guarantee payments to Vanguard. Accounting for minimum revenue guarantees requires that a liability be recorded at fair value for all guarantees entered into on or after January 1, 2006. Vanguard determines this liability and an offsetting intangible asset by calculating an estimate of expected payments to be made over the guarantee period. Vanguard reduces the liability as it makes guarantee payments and amortizes the intangible asset over the term of the physicians' relocation agreements. Vanguard also estimates the fair value of liabilities and offsetting intangible assets related to payment guarantees for physician service agreements for which no repayment provisions exist. As of March 31, 2010, Vanguard had a net intangible asset of $8.5 million and a remaining liability of $2.8 million related to these physician income and service guarantees. The maximum amount of Vanguard's unpaid physician income and service guarantees as of March 31, 2010 was approximately $3.7 million.

Other Guarantees

As part of its contract with the Arizona Health Care Cost Containment System, one of Vanguard's health plans, Phoenix Health Plan, is required to maintain a performance guarantee, the amount of which is based upon Plan membership and capitation premiums received. As of March 31, 2010, Vanguard maintained this performance guarantee in the form of $50.0 million of surety bonds with independent third party insurers collateralized by letters of credit of approximately $5.0 million.

14. FINANCIAL INFORMATION FOR SUBSIDIARY GUARANTORS AND NON-GUARANTOR SUBSIDIARIES

Vanguard conducts substantially all of its business through its subsidiaries. Most of Vanguard's subsidiaries had previously jointly and severally guaranteed the 9.0% Notes on a subordinated basis and currently jointly and severally guarantee the 8.0% Notes. Certain of Vanguard's other consolidated wholly-owned and non wholly-owned entities did not previously guarantee the 9.0% Notes and currently do not guarantee the 8.0% Notes in conformity with the provisions of the indentures governing those notes and do not guarantee the 2010 credit facilities in conformity with the provisions thereof. The condensed consolidating financial information for the parent company, the issuers of the senior notes (both the previous 9.0% Notes and the new 8.0% Notes), the issuers of the senior discount notes (the 11.25% Notes), the subsidiary guarantors, the non-guarantor subsidiaries, certain eliminations and consolidated Vanguard as of June 30, 2009 and March 31, 2010 and for the three and nine months ended March 31, 2009 and 2010 follows.

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
June 30, 2009
(Unaudited)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 168.3	$ 139.9	$ –	$ 308.2
Restricted cash	–	–	–	0.2	1.7	–	1.9
Accounts receivable, net	–	–	–	257.0	18.3	–	275.3
Inventories	–	–	–	44.5	3.8	–	48.3
Prepaid expenses and other current assets	2.5	–	–	94.9	34.6	(34.0)	98.0
Total current assets	2.5	–	–	564.9	198.3	(34.0)	731.7
Property, plant and equipment, net	–	–	–	1,114.7	59.4	–	1,174.1
Goodwill	–	–	–	608.5	83.6	–	692.1
Intangible assets, net	–	19.4	2.9	13.5	18.8	–	54.6
Investments in consolidated subsidiaries	608.8	–	–	–	24.5	(633.3)	–
Investments in auction rate securities	–	–	–	–	21.6	–	21.6
Other assets	–	–	–	56.8	0.2	–	57.0
Total assets	$ 611.3	$ 19.4	$ 2.9	$ 2,358.4	$ 406.4	$ (667.3)	$ 2,731.1
LIABILITIES AND EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 112.7	$ 15.2	$ –	$ 127.9
Accrued expenses and other current liabilities	–	20.0	–	201.9	122.3	–	344.2
Current maturities of long-term debt	–	8.0	–	(0.2)	0.2	–	8.0
Total current liabilities	–	28.0	–	314.4	137.7	–	480.1
Other liabilities	–	–	–	71.9	73.7	(34.0)	111.6
Long-term debt, less current maturities	–	1,333.4	210.2	–	–	–	1,543.6
Intercompany	15.5	(810.4)	(120.9)	1,314.8	(60.1)	(338.9)	–
Equity	595.8	(531.6)	(86.4)	657.3	255.1	(294.4)	595.8
Total liabilities and equity	$ 611.3	$ 19.4	$ 2.9	$ 2,358.4	$ 406.4	$ (667.3)	$ 2,731.1

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING BALANCE SHEETS
March 31, 2010
(Unaudited)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
ASSETS							
Current assets:							
Cash and cash equivalents	$ –	$ –	$ –	$ 156.1	$ 54.2	$ –	$ 210.3
Restricted cash	–	–	–	0.3	1.7	–	2.0
Accounts receivable, net	–	–	–	273.8	21.0	–	294.8
Inventories	–	–	–	45.4	3.8	–	49.2
Prepaid expenses and other current assets	0.1	–	–	57.8	25.3	(8.5)	74.7
Total current assets	0.1	–	–	533.4	106.0	(8.5)	631.0
Property, plant and equipment, net	–	–	–	1,117.3	56.1	–	1,173.4
Goodwill	–	–	–	565.5	83.6	–	649.1
Intangible assets, net	–	37.2	–	15.6	16.1	–	68.9
Investments in consolidated subsidiaries	608.8	–	–	–	24.5	(633.3)	–
Investments in auction rate securities	–	–	–	–	21.6	–	21.6
Other assets	–	–	–	83.6	0.1	–	83.7
Total assets	$ 608.9	$ 37.2	$ –	$ 2,315.4	$ 308.0	$ (641.8)	$ 2,627.7
LIABILITIES AND EQUITY							
Current liabilities:							
Accounts payable	$ –	$ –	$ –	$ 145.1	$ 23.1	$ –	$ 168.2
Accrued expenses and other current liabilities	–	17.8	–	182.8	147.4	–	348.0
Current maturities of long-term debt	–	8.2	–	(0.2)	0.2	–	8.2
Total current liabilities	–	26.0	–	327.7	170.7	–	524.4
Other liabilities	–	–	–	74.5	43.2	(8.5)	109.2
Long-term debt, less current maturities	–	1,743.4	–	–	–	–	1,743.4
Intercompany	358.2	(1,060.0)	–	1,204.1	(183.7)	(318.6)	–
Total equity (deficit)	250.7	(672.2)	–	709.1	277.8	(314.7)	250.7
Total liabilities and equity	$ 608.9	$ 37.2	$ –	$ 2,315.4	$ 308.0	$ (641.8)	$ 2,627.7

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the three months ended March 31, 2009
(Unaudited)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 639.0	$ 42.6	$ (5.5)	$ 676.1
Premium revenues	–	–	–	15.2	166.8	(0.1)	181.9
Total revenues	–	–	–	654.2	209.4	(5.6)	858.0
Salaries and benefits	1.2	–	–	303.6	23.6	–	328.4
Health plan claims expense	–	–	–	8.9	139.6	(5.5)	143.0
Supplies	–	–	–	106.7	8.6	–	115.3
Provision for doubtful accounts	–	–	–	49.9	2.6	–	52.5
Purchased services	–	–	–	39.4	3.9	–	43.3
Other operating expenses	0.1	–	–	70.1	9.4	(0.1)	79.5
Rents and leases	–	–	–	9.2	1.8	–	11.0
Depreciation and amortization	–	–	–	28.2	3.4	–	31.6
Interest, net	–	22.4	5.5	(1.7)	1.0	–	27.2
Management fees	–	–	–	(3.5)	3.5	–	–
Other	–	–	–	1.8	(0.6)	–	1.2
Total costs and expenses	1.3	22.4	5.5	612.6	196.8	(5.6)	833.0
Income (loss) from continuing operations before income taxes	(1.3)	(22.4)	(5.5)	41.6	12.6	–	25.0
Income tax benefit (expense)	(8.2)	–	–	–	(3.5)	3.5	(8.2)
Equity in earnings of subsidiaries	25.3	–	–	–	–	(25.3)	–
Income (loss) from continuing operations	15.8	(22.4)	(5.5)	41.6	9.1	(21.8)	16.8
Loss from discontinued operations, net of taxes	–	–	–	(0.2)	(0.1)	–	(0.3)
Net income (loss)	15.8	(22.4)	(5.5)	41.4	9.0	(21.8)	16.5
Less: Net income attributable to non-controlling interests	–	–	–	(0.7)	–	–	(0.7)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 15.8	$ (22.4)	$ (5.5)	$ 40.7	$ 9.0	$ (21.8)	$ 15.8

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the three months ended March 31, 2010
(Unaudited)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 622.9	$ 45.2	$ (18.3)	$ 649.8
Premium revenues	–	–	–	14.6	204.3	(7.5)	211.4
Total revenues	–	–	–	637.5	249.5	(25.8)	861.2
Salaries and benefits	0.6	–	–	304.0	24.1	–	328.7
Health plan claims expense	–	–	–	18.8	167.6	(18.3)	168.1
Supplies	–	–	–	105.6	8.5	–	114.1
Provision for doubtful accounts	–	–	–	39.1	1.6	–	40.7
Purchased services	–	–	–	39.3	6.1	–	45.4
Other operating expenses	0.1	–	–	54.0	16.9	(7.5)	63.5
Rents and leases	–	–	–	9.3	1.9	–	11.2
Depreciation and amortization	–	–	–	31.7	2.9	–	34.6
Interest, net	–	28.5	2.2	(1.7)	0.9	–	29.9
Management fees	–	–	–	(4.2)	4.2	–	–
Impairment loss	–	–	–	–	–	–	–
Debt extinguishment costs	–	67.5	5.7	–	–	–	73.2
Other	–	–	–	0.9	–	–	0.9
Total costs and expenses	0.7	96.0	7.9	596.8	234.7	(25.8)	910.3
Income (loss) from continuing operations before income taxes	(0.7)	(96.0)	(7.9)	40.7	14.8	–	(49.1)
Income tax benefit (expense)	16.5	–	–	–	(5.2)	5.2	16.5
Equity in earnings of subsidiaries	(48.6)	–	–	–	–	48.6	–
Income (loss) from continuing operations	(32.8)	(96.0)	(7.9)	40.7	9.6	53.8	(32.6)
Income from discontinued operations, net of taxes	–	–	–	0.2	–	–	0.2
Net income (loss)	(32.8)	(96.0)	(7.9)	40.9	9.6	53.8	(32.4)
Less: Net income attributable to non-controlling interests	–	–	–	(0.4)	–	–	(0.4)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ (32.8)	(96.0)	(7.9)	40.5	9.6	53.8	(32.8)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the nine months ended March 31, 2009
(Unaudited)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 1,782.4	$ 123.6	$ (17.2)	$ 1,888.8
Premium revenues	–	–	–	45.4	435.6	(0.2)	480.8
Total revenues	–	–	–	1,827.8	559.2	(17.4)	2,369.6
Salaries and benefits	3.4	–	–	852.7	67.6	–	923.7
Health plan claims expense	–	–	–	26.2	361.7	(17.2)	370.7
Supplies	–	–	–	315.5	24.4	–	339.9
Provision for doubtful accounts	–	–	–	147.8	7.6	–	155.4
Purchased services	–	–	–	114.0	11.0	–	125.0
Other operating expenses	0.2	–	–	170.4	27.5	(0.2)	197.9
Rents and leases	–	–	–	27.4	5.1	–	32.5
Depreciation and amortization	–	–	–	85.4	10.6	–	96.0
Interest, net	–	71.5	16.2	(4.6)	1.4	–	84.5
Management fees	–	–	–	(10.5)	10.5	–	–
Other	–	–	–	2.0	–	–	2.0
Total costs and expenses	3.6	71.5	16.2	1,726.3	527.4	(17.4)	2,327.6
Income (loss) from continuing operations before income taxes	(3.6)	(71.5)	(16.2)	101.5	31.8	–	42.0
Income tax benefit (expense)	(13.5)	–	–	–	(10.2)	10.2	(13.5)
Equity in earnings of subsidiaries	43.9	–	–	–	–	(43.9)	–
Income (loss) from continuing operations	26.8	(71.5)	(16.2)	101.5	21.6	(33.7)	28.5
Income from discontinued operations, net of taxes	–	–	–	0.3	0.3	–	0.6
Net income (loss)	26.8	(71.5)	(16.2)	101.8	21.9	(33.7)	29.1
Less: Net income attributable to non-controlling interests	–	–	–	(2.3)	–	–	(2.3)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 26.8	$ (71.5)	$ (16.2)	$ 99.5	$ 21.9	$ (33.7)	$ 26.8

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS
For the nine months ended March 31, 2010
(Unaudited)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Patient service revenues	$ –	$ –	$ –	$ 1,796.1	$ 135.8	$ (31.7)	$ 1,900.2
Premium revenues	–	–	–	45.2	605.8	(23.0)	628.0
Total revenues	–	–	–	1,841.3	741.6	(54.7)	2,528.2
Salaries and benefits	3.5	–	–	891.7	72.4	–	967.6
Health plan claims expense	–	–	–	35.1	496.5	(31.7)	499.9
Supplies	–	–	–	314.2	25.7	–	339.9
Provision for doubtful accounts	–	–	–	107.2	5.7	–	112.9
Purchased services	–	–	–	120.6	17.1	–	137.7
Other operating expenses	0.2	–	–	171.0	49.4	(23.0)	197.6
Rents and leases	–	–	–	27.9	5.6	–	33.5
Depreciation and amortization	–	–	–	93.3	9.6	–	102.9
Interest, net	–	73.1	14.3	(5.3)	2.5	–	84.6
Management fees	–	–	–	(12.7)	12.7	–	–
Impairment loss	–	–	–	43.1	–	–	43.1
Debt extinguishment costs	–	67.5	5.7	–	–	–	73.2
Other	–	–	–	3.5	–	–	3.5
Total costs and expenses	3.7	140.6	20.0	1,789.6	697.2	(54.7)	2,596.4
Income (loss) from continuing operations before income taxes	(3.7)	(140.6)	(20.0)	51.7	44.4	–	(68.2)
Income tax benefit (expense)	18.2	–	–	–	(15.6)	15.6	18.2
Equity in earnings of subsidiaries	(66.5)	–	–	–	–	66.5	–
Income (loss) from continuing operations	(52.0)	(140.6)	(20.0)	51.7	28.8	82.1	(50.0)
Income from discontinued operations, net of taxes	–	–	–	0.1	–	–	0.1
Net income (loss)	(52.0)	(140.6)	(20.0)	51.8	28.8	82.1	(49.9)
Less: Net income attributable to non-controlling interests	–	–	–	(2.1)	–	–	(2.1)
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ (52.0)	$ (140.6)	$ (20.0)	$ 49.7	$ 28.8	$ 82.1	$ (52.0)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the nine months ended March 31, 2009
(Unaudited)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ 26.8	$ (71.5)	$ (16.2)	$ 101.8	$ 21.9	$ (33.7)	$ 29.1
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities							
Income from discontinued operations, net of taxes	–	–	–	(0.3)	(0.3)	–	(0.6)
Depreciation and amortization	–	–	–	85.4	10.6	–	96.0
Provision for doubtful accounts	–	–	–	147.8	7.6	–	155.4
Deferred income taxes	(1.0)	–	–	–	–	–	(1.0)
Amortization of loan costs	–	3.8	0.2	–	–	–	4.0
Accretion of principal on notes	–	–	16.0	–	–	–	16.0
Gain on sale of assets	–	–	–	(2.1)	–	–	(2.1)
Stock compensation	3.4	–	–	–	–	–	3.4
Realized loss on investments	–	–	–	–	0.6	–	0.6
Changes in operating assets and liabilities, net of effects of acquisitions:							
Equity in earnings of subsidiaries	(43.9)	–	–	–	–	43.9	–
Accounts receivable	–	–	–	(160.5)	(14.0)	–	(174.5)
Inventories	–	–	–	(0.3)	–	–	(0.3)
Prepaid expenses and other current assets	–	–	–	4.3	1.1	–	5.4
Accounts payable	–	–	–	10.1	4.9	–	15.0
Accrued expenses and other liabilities	14.7	21.2	–	49.9	28.8	(10.2)	104.4
Net cash provided by (used in) operating activities - continuing operations	–	(46.5)	–	236.1	61.2	–	250.8
Net cash provided by operating activities - discontinued operations	–	–	–	0.3	0.3	–	0.6
Net cash provided by (used in) operating activities	–	(46.5)	–	236.4	61.5	–	251.4
Investing activities:							
Capital expenditures	–	–	–	(82.7)	(4.6)	–	(87.3)
Acquisitions	–	–	–	(3.7)	–	–	(3.7)
Proceeds from asset dispositions	–	–	–	4.0	–	–	4.0
Other	–	–	–	(4.3)	–	–	(4.3)
Net cash used in investing activities	–	–	–	(86.7)	(4.6)	–	(91.3)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the nine months ended March 31, 2009
(Unaudited)
(continued)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	$ –	$ (5.8)	$ –	$ –	$ –	$ –	$ (5.8)
Payments to retire stock and stock options	–	–	–	(0.2)	–	–	(0.2)
Distributions	–	–	–	–	(3.5)	–	(3.5)
Cash provided by (used in) intercompany activity	–	52.3	–	26.3	(78.6)	–	–
Net cash provided by (used in) financing activities	–	46.5	–	26.1	(82.1)	–	(9.5)
Net increase (decrease) in cash and cash equivalents	–	–	–	175.8	(25.2)	–	150.6
Cash and cash equivalents, beginning of period	–	–	–	82.0	59.6	–	141.6
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 257.8	$ 34.4	$ –	$ 292.2

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the nine months ended March 31, 2010
(Unaudited)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Operating activities:							
Net income (loss)	$ (52.0)	$ (140.6)	$ (20.0)	$ 51.8	$ 28.8	$ 82.1	$ (49.9)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:							
Income from discontinued operations, net of taxes	–	–	–	(0.1)	–	–	(0.1)
Depreciation and amortization	–	–	–	93.3	9.6	–	102.9
Provision for doubtful accounts	–	–	–	107.2	5.7	–	112.9
Deferred income taxes	(20.0)	–	–	–	–	–	(20.0)
Amortization of loan costs	–	3.8	0.3	–	–	–	4.1
Accretion of principal on notes	–	0.3	5.8	–	–	–	6.1
Debt extinguishment costs	–	67.5	5.7	–	–	–	73.2
Loss on disposal of assets	–	–	–	0.5	–	–	0.5
Stock compensation	3.5	–	–	–	–	–	3.5
Impairment loss	–	–	–	43.1	–	–	43.1
Changes in operating assets and liabilities:							
Equity in earnings of subsidiaries	66.5	–	–	–	–	(66.5)	–
Accounts receivable	–	–	–	(124.1)	(8.3)	–	(132.4)
Inventories	–	–	–	(1.0)	0.1	–	(0.9)
Prepaid expenses and other current assets	–	–	–	(22.1)	9.3	–	(12.8)
Accounts payable	–	–	–	32.4	7.8	–	40.2
Accrued expenses and other liabilities	2.0	(2.1)	–	69.2	(5.3)	(15.6)	48.2
Net cash provided by (used in) operating activities - continuing operations	–	(71.1)	(8.2)	250.2	47.7	–	218.6
Net cash provided by operating activities - discontinued operations	–	–	–	0.1	–	–	0.1
Net cash provided by (used in) operating activities	–	(71.1)	(8.2)	250.3	47.7	–	218.7
Investing activities:							
Capital expenditures	–	–	–	(107.4)	(3.7)	–	(111.1)
Acquisitions	–	–	–	(1.5)	–	–	(1.5)
Proceeds from asset dispositions	–	–	–	1.5	–	–	1.5
Other	–	–	–	(0.3)	–	–	(0.3)
Net cash used in investing activities	–	–	–	(107.7)	(3.7)	–	(111.4)

VANGUARD HEALTH SYSTEMS, INC.
CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS
For the nine months ended March 31, 2010
(Unaudited)
(continued)

	Parent	Issuers of Senior Notes and Term Debt	Issuers of Senior Discount Notes	Guarantor Subsidiaries	Combined Non-Guarantors	Eliminations	Total Consolidated
				(In millions)			
Financing activities:							
Payments of long-term debt	$ –	$ (1,341.4)	$ (216.0)	$ –	$ –	$ –	$ (1,557.4)
Proceeds from debt borrowings	–	1,751.3	–	–	–	–	1,751.3
Payments of refinancing costs and fees	–	(76.8)	(13.3)	–	–	–	(90.1)
Repurchases of stock	(300.6)	–	–	–	–	–	(300.6)
Financing portion of hedge interest payments	(6.0)	–	–	–	–	–	(6.0)
Distributions	–	–	–	–	(6.1)	3.7	(2.4)
Cash provided by (used in) intercompany activity	306.6	(262.0)	237.5	(154.8)	(123.6)	(3.7)	–
Net cash provided by (used in) financing activities	–	71.1	8.2	(154.8)	(129.7)	–	(205.2)
Net decrease in cash and cash equivalents	–	–	–	(12.2)	(85.7)	–	(97.9)
Cash and cash equivalents, beginning of period	–	–	–	168.3	139.9	–	308.2
Cash and cash equivalents, end of period	$ –	$ –	$ –	$ 156.1	$ 54.2	$ –	$ 210.3

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

Forward Looking Statements

This report on Form 10-Q contains "forward-looking statements" within the meaning of the federal securities laws which are intended to be covered by the safe harbors created thereby. Forward-looking statements are those statements that are based upon management's current plans and expectations as opposed to historical and current facts and are often identified in this report by use of words including but not limited to "may," "believe," "will," "project," "expect," "estimate," "anticipate," and "plan." These statements are based upon estimates and assumptions made by Vanguard's management that, although believed to be reasonable, are subject to numerous factors, risks and uncertainties that could cause actual outcomes and results to be materially different from those projected. These factors, risks and uncertainties include, among others, the following:

- Our high degree of leverage and interest rate risk
- Our ability to incur substantially more debt
- Operating and financial restrictions in our debt agreements
- Our ability to generate cash necessary to service our debt
- Weakened economic conditions and volatile capital markets
- Potential liability related to disclosures of relationships between physicians and our hospitals
- Post-payment claims reviews by governmental agencies could result in additional costs to us
- Our ability to successfully implement our business strategies
- Our ability to grow our business and successfully integrate future acquisitions
- Potential acquisitions could be costly, unsuccessful or subject us to unexpected liabilities
- Conflicts of interest that may arise as a result of our control by a small number of stockholders
- The highly competitive nature of the healthcare industry
- Governmental regulation of the industry, including Medicare and Medicaid reimbursement levels
- Pressures to contain costs by managed care organizations and other insurers and our ability to negotiate acceptable terms with these third party payers
- Our ability to attract and retain qualified management and healthcare professionals, including physicians and nurses
- The currently unknown effect on us of the major federal healthcare reforms enacted by Congress in March 2010 or other potential additional federal or state healthcare reforms
- Future governmental investigations
- Our failure to adequately enhance our facilities with technologically advanced equipment could adversely affect our revenues and market position
- Potential lawsuits or other claims asserted against us
- The availability of capital to fund our corporate growth strategy
- Our ability to maintain or increase patient membership and control costs of our managed healthcare plans
- Our exposure to the increased amounts of and collection risks associated with uninsured accounts and the co-pay and deductible portions of insured accounts
- Dependence on our senior management team and local management personnel
- Volatility of professional and general liability insurance for us and the physicians who practice at our hospitals and increases in the quantity and severity of professional liability claims
- Our ability to maintain and increase patient volumes and control the costs of providing services, including salaries and benefits, supplies and bad debts
- Increased costs from further government regulation of healthcare and our failure to comply, or allegations of our failure to comply, with applicable laws and regulations
- The geographic concentration of our operations
- Technological and pharmaceutical improvements that increase the cost of providing, or reduce the demand for, healthcare services and shift demand for inpatient services to outpatient settings
- Costs and compliance risks associated with Section 404 of the Sarbanes-Oxley Act of 2002
- A failure of our information systems would adversely impact our ability to manage our operations
- Material non-cash charges to earnings from impairment of goodwill associated with declines in the fair market values of our reporting units
- Volatility of materials and labor costs for, or state efforts to regulate, potential construction projects that may be necessary for future growth

Our forward-looking statements speak only as of the date made. Except as required by law, we undertake no obligation to publicly update or revise any forward-looking statements contained herein, whether as a result of new information, future events or otherwise. We advise you, however, to consult any additional disclosures we make in our other filings with the Securities and Exchange Commission, including, without limitation, the discussion of risks and other uncertainties under the caption "Item 1A. Risk Factors" included later in this report. You are cautioned to not rely on such forward-looking statements when evaluating the information contained in this report. In light of the significant uncertainties inherent in the forward-looking statements included in this report, you should not regard the inclusion of such information as a representation by us that our objectives and plans anticipated by the forward-looking statements will occur or be achieved, or if any of them do, what impact they will have on our results of operations and financial condition.

Executive Overview

As of March 31, 2010, we owned and operated 15 hospitals with a total of 4,135 licensed beds, and related outpatient service facilities complementary to the hospitals in San Antonio, Texas; metropolitan Phoenix, Arizona; metropolitan Chicago, Illinois; and Massachusetts, and two surgery centers in Orange County, California. As of March 31, 2010, we also owned three health plans as set forth in the following table.

Health Plan	Location	Membership
Phoenix Health Plan ("PHP") – managed Medicaid	Arizona	200,500
Abrazo Advantage Health Plan ("AAHP") – managed Medicare and Dual Eligible	Arizona	2,700
MacNeal Health Providers ("MHP") – capitated outpatient and physician services	Illinois	37,100
		240,300

Our objective is to help people in the communities we serve achieve health for life by delivering an ideal patient-centered experience in a highly reliable environment of care. We plan to grow our business by improving quality of care, expanding services and strengthening the financial performance of our existing operations and selectively acquiring other hospitals where we see an opportunity to improve operating performance and profitability.

Potential Significant Acquisition

On March 19, 2010, we announced that we had entered into a non-binding letter of intent with Detroit Medical Center ("DMC"), which owns and operates eight hospitals in and around Detroit, Michigan with 1,734 licensed beds, including Children's Hospital of Michigan, Detroit Receiving Hospital, Harper University Hospital, Huron Valley-Sinai Hospital, Hutzel Women's Hospital, Rehabilitation Institute of Michigan, Sinai-Grace Hospital and DMC Surgery Hospital.

Under the letter of intent, we will acquire all of DMC's assets (other than donor restricted assets) and assume all of its liabilities (other than its outstanding bonds and similar debt) for $417.0 million in cash, which will be used to repay or defease all of such non-assumed debt. The $417.0 million cash payment represents our full cash funding obligations to DMC in order to close the transaction, except for our assumption or payment of DMC's usual and customary transaction expenses. The assumed liabilities include a pension liability under a "frozen" defined benefit pension plan of DMC currently estimated at $184 million that we anticipate we will fund over seven years based upon current actuarial assumptions and estimates, as adjusted periodically by actuaries. We will also commit to spend $500.0 million in capital expenditures in the DMC facilities during the five years subsequent to closing of the transaction, which amount relates to a specific project list agreed to between the DMC board of directors and us. In addition, we will commit to spend $350.0 million during this five-year period relating to the routine capital needs of the DMC facilities.

The non-binding letter of intent extends through June 1, 2010, at which time the parties are required to have completed a mutually acceptable binding definitive acquisition agreement. If the definitive agreement is not completed by June 1, 2010, the letter of intent will terminate unless extended mutually by DMC and us. The execution of the definitive agreement is subject to satisfactory completion of our due diligence with regards to the operations, assets and liabilities of DMC and the approval of the boards of directors of both DMC and Vanguard. The definitive agreement will provide that the closing of this proposed transaction will be subject to (i) the receipt by the parties of all governmental regulatory approvals, permits and

licenses necessary to have been received as of the closing; (ii) city, county and state approval of a Wayne County Michigan Renaissance Zone that would provide significant long-term local and state tax incentives and would encompass an area that includes DMC's central campus; and (iii) other conditions to closing to be negotiated by the parties and set forth in the definitive agreement. We cannot give any assurance that the acquisition will be completed as currently planned or at all.

Operating Environment

We believe that the operating environment for hospital operators continues to evolve, which presents both challenges and opportunities for us. In order to remain competitive in the markets we serve, we must transform our operating strategies to not only accommodate changing environmental factors but to make them operating advantages for us relative to our peers. These factors will require continued focus on quality of care initiatives. As consumers become more involved in their healthcare decisions, we believe perceived quality of care will become an even greater factor in determining where physicians choose to practice and where patients choose to receive care. In the following paragraphs we discuss both current challenges and future challenges that we face and our strategies to proactively address them.

Pay for Performance Reimbursement

Many payers, including Medicare and several large managed care organizations, currently require hospital providers to report certain quality measures in order to receive the full amount of payment increases that were awarded automatically in the past. For federal fiscal year 2010, Medicare expanded the number of quality measures to be reported to 47 compared to 43 during federal fiscal year 2009. Many large managed care organizations have developed quality measurement criteria that are similar to or even more stringent than these Medicare requirements. We believe it is only a matter of time until all significant payers utilize the quality measures themselves to determine reimbursement rates for hospital services. In order to meet these requirements, we must deliver an ideal patient-centered experience. This will require us to engage our nurses and partner with physicians to drive our quality of care strategies, to invest in and upgrade our information technology systems to monitor clinical quality indicators and to make all of our processes more efficient.

Physician Alignment

Our ability to attract skilled physicians to our hospitals is critical to our success. Coordination of care and alignment of care strategies between hospitals and physicians will become more critical as reimbursement becomes more episode-based. We have adopted several significant physician recruitment goals with primary emphasis on recruiting physicians specializing in family practice, internal medicine, obstetrics and gynecology, cardiology, neurology, orthopedics and inpatient hospital care (hospitalists). To provide our patients access to the appropriate physician resources, we actively recruit physicians to the communities served by our hospitals through employment agreements, relocation agreements or physician practice acquisitions. We have invested heavily in the infrastructure necessary to coordinate our physician alignment strategies and manage our physician operations. Our hospitalist employment strategy is a key element in coordination of patient-centered care. The costs associated with recruiting, integrating and managing such a large number of new physicians has had and will continue to have a negative impact on our operating results and cash flows in the short term. However, we expect to realize improved clinical quality and service expansion capabilities from this initiative that will positively impact our operating results over the long-term.

Cost pressures

In order to demonstrate a highly reliable environment of care, we must hire and retain nurses who share our ideals and beliefs and who have access to the training necessary to implement our clinical quality initiatives. While the national nursing shortage has abated somewhat during the past year, the nursing workforce remains volatile. As a result, we expect continuing pressures on nursing salaries and benefits costs. These pressures include higher than normal base wage increases, demands for flexible working hours and other increased benefits and higher nurse to patient ratios necessary to improve quality of care. Inflationary pressures and technological advancements continue to drive supplies costs higher. We have implemented multiple supply chain initiatives including consolidation of low-priced vendors, establishment of value analysis teams and coordination of care efforts with physicians to reduce physician preference items.

Healthcare Reform

On March 21, 2010, the House passed the "Patient Protection and Affordable Care Act," the exact version of a healthcare reform bill previously passed by the Senate on December 24, 2009, and the "Health Care and Education Affordability Reconciliation Act of 2010," an accompanying bill that made certain adjustments to the original Senate bill, the most notable of which included more generous subsidies to lower income families to purchase insurance, a delay until 2018 of the tax assessed to generous employer-sponsored health plans and a gradual closing of the Medicare Part D "donut hole." The original Senate bill and the accompanying House bill (as amended by the Senate) were signed by President Obama into law on March 23, 2010 and March 30, 2010, respectively.

The provisions included in the combination of these two bills generally provide increased access to health benefits for uninsured or underinsured populations through the creation of state-based health insurance exchanges and expansion of coverage under Medicaid programs but excludes a public insurance option. Under the combined bills, federal health program expenditures are estimated to be reduced by more than $480.0 billion over 10 years through reductions in the annual market basket updates for Medicare fee-for-service providers, reduced subsidies to Medicare Advantage health plans, reductions in Medicare and Medicaid disproportionate share funding and cuts in payments to hospitals with high readmission rates. The expansion of Medicaid programs could result in additional utilization at our facilities with lower reimbursement than the cost required to provide such services. The combined bills also include pilot programs for hospitals to provide value-based care and to penalize hospitals that perform poorly on certain quality measures and may result in additional medical information technology investments by us.

Most of the provisions of these healthcare bills do not go into effect immediately and may be delayed for several years. During this time, the bills may be subject to further adjustments through future legislation or even constitutional challenges. We will not be able to determine the effects of either or both of these bills on our results of operations, financial position and cash flows for a significant period of time.

Implementation of our Clinical Quality Initiatives

The integral component of each of the challenge areas previously discussed is quality of care. We have implemented many of our expanded clinical quality initiatives and are in the process of implementing several others. These initiatives include monthly review of the 47 CMS quality indicators in place for federal fiscal year 2010, rapid response teams, mock Joint Commission surveys, hourly nursing rounds, our nurse leadership professional practice model, alignment of hospital management incentive compensation with quality performance indicators and the formation of Physician Advisory Councils at our hospitals to align the quality goals of our hospitals with those of the physicians who practice in our hospitals.

Sources of Revenues

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Charges and reimbursement rates for inpatient services vary significantly depending on the type of payer, the type of service (e.g., acute care, intensive care or subacute) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

We receive payment for patient services from:

- the federal government, primarily under the Medicare program;
- state Medicaid programs;
- health maintenance organizations, preferred provider organizations, managed Medicare providers, managed Medicaid providers and other private insurers; and
- individual patients

The following table sets forth the percentages of net patient revenues by payer for the three months and nine months ended March 31, 2009 and 2010.

	Three months ended March 31,		Nine months ended March 31,	
	2009	2010	2009	2010
Medicare	24.7%	26.1%	25.4%	25.5%
Medicaid	9.0%	7.4%	7.9%	7.3%
Managed Medicare	14.0%	14.8%	13.9%	14.8%
Managed Medicaid	8.2%	9.4%	8.8%	9.7%
Managed care	35.5%	34.7%	35.1%	34.9%
Self pay	7.8%	6.5%	8.0%	6.7%
Other	0.8%	1.1%	0.9%	1.1%
Total	100.0%	100.0%	100.0%	100.0%

The Medicare program, the nation's largest health insurance program, is administered by CMS. Medicare provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease without regard to beneficiary income or assets. Medicaid is a federal-state program, administered by the states, which provides hospital and medical benefits to qualifying individuals who are unable to afford healthcare. All of our general, acute care hospitals located in the United States are certified as healthcare services providers for persons covered under the Medicare and the various state Medicaid programs. Amounts received under these programs are generally significantly less than established hospital gross charges for the services provided.

In our June 30, 2009 Form 10-K, we described the types of payments we receive for services provided to patients enrolled in the traditional Medicare plan (both for inpatient and outpatient services), managed Medicare plans, Medicaid plans, managed Medicaid plans and managed care plans. We also discussed the unique reimbursement features of the traditional Medicare plan, including disproportionate share, outlier cases and direct graduate and indirect medical education. The annual Medicare regulatory updates published by CMS in August 2009 that impact reimbursement rates under the plan for services provided during the federal fiscal year beginning October 1, 2009 were also discussed in our June 30, 2009 Form 10-K.

Our hospitals offer discounts from established charges to certain group purchasers of healthcare services, including private insurance companies, employers, health maintenance organizations, preferred provider organizations and other managed care plans as well as uninsured discounts for patients with no insurance coverage at most of our hospitals. These discount programs limit our ability to increase patient service revenues in response to increasing costs. Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid and managed care programs, but are generally responsible for exclusions, deductibles and coinsurance features of their coverages. Due to rising healthcare costs, many payers have increased the number of excluded services and the levels of deductibles and coinsurance resulting in a higher portion of the contracted rate due from the individual patients. Collecting amounts due from individual patients is typically more difficult than collecting from governmental or private managed care plans.

Volumes by Payer

During the nine months ended March 31, 2010 compared to the prior year period, discharges decreased 0.2% and total adjusted discharges increased 2.0%. The following table provides details of discharges by payer for the three and nine months ended March 31, 2009 and 2010.

	Three months ended March 31,				Nine months ended, March 31,			
	2009		2010		2009		2010	
Medicare	11,811	27.7%	11,953	28.3%	34,442	27.2%	34,653	27.5%
Medicaid (1)	4,274	10.0%	3,693	8.7%	13,038	10.3%	10,957	8.7%
Managed Medicare	7,168	16.8%	7,067	16.7%	20,082	15.9%	20,522	16.3%
Managed Medicaid	5,725	13.5%	6,364	15.1%	17,285	13.7%	19,317	15.3%
Managed care	12,171	28.6%	11,087	26.2%	37,270	29.5%	34,015	26.9%
Self pay (2)	1,322	3.1%	1,963	4.6%	3,957	3.1%	6,226	4.9%
Other	124	0.3%	166	0.4%	406	0.3%	521	0.4%
Total	42,595	100.0%	42,293	100.0%	126,480	100.0%	126,211	100.0%

(1) Medicaid discharges would have been 4,327 and 13,074 during the three months and nine months ended March 31, 2010, respectively, had the Medicaid pending policy not been changed during the current year period.

(2) Self pay discharges would have been 1,329 and 4,109 during the three months and nine months ended March 31, 2010, respectively, had the Medicaid pending policy not been changed during the current year period.

Payer Reimbursement Trends

In addition to the volume factors described above, patient mix, acuity factors and pricing trends affect our patient service revenues. Net patient revenue per adjusted discharge was $8,544 and $8,422 for the nine months ended March 31, 2009 and 2010, respectively. This decrease was primarily due to the uninsured discount policy that we implemented in our Chicago hospitals on April 1, 2009 and in our Phoenix and San Antonio hospitals on July 1, 2009. Under this policy, we apply an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing for those patients with no insurance coverage who do not qualify for charity care under our guidelines. We recorded $161.0 million of uninsured discount revenue deductions during the nine months ended March 31, 2010, $95.2 million of which would have otherwise been included in net patient revenues and subjected to our allowance for doubtful accounts policy had we not implemented our uninsured discount policy at these hospitals.

Impact of Current Economic Environment

We continue to experience limited volume growth due to stagnant demand for inpatient healthcare services and increased competition for available patients. The current weakened economic environment has negatively impacted many industries. While many healthcare services are considered non-discretionary in nature, certain services including elective procedures and other non-emergent services may be deferred or canceled by patients when they are suffering personal financial hardship or have a negative outlook on the general economy. Increases in unemployment often result in a higher number of uninsured patients, and employer cost reduction programs may result in a higher level of co-pays and deductible limits for patients. Governmental payers and managed care payers may reduce reimbursement paid to hospitals and other healthcare providers to address budget shortfalls or enrollment declines. We are unable to determine the specific impact of the weakened economic environment to our results of operations or cash flows. However, we believe these economic conditions have negatively impacted our volumes and payer mix during the current year period to some degree. We expect our volumes to improve more significantly over the long-term as a result of our quality of care and service expansion initiatives and other market-specific strategies, especially as more individuals in the markets we serve reach ages where hospital services become more prevalent.

However, we have no way to estimate when the economy may improve or when we will realize the benefits of our long-term strategies.

Accounts Receivable Collection Risks Leading to Increased Bad Debts

Similar to other companies in the hospital industry, we face continued pressures in collecting outstanding accounts receivable primarily due to volatility in the uninsured and underinsured populations in the markets we serve. The following table provides a summary of our accounts receivable payer class mix as of each respective period presented.

June 30, 2009	0-90 days	91-180 days	Over 180 days	Total
Medicare	15.6%	0.3%	0.3%	16.2%
Medicaid	6.7%	0.9%	1.0%	8.6%
Managed Medicare	10.0%	0.5%	0.3%	10.8%
Managed Medicaid	7.1%	0.5%	0.5%	8.1%
Managed Care	25.1%	2.3%	1.5%	28.9%
Self-Pay[1]	9.7%	8.1%	0.8%	18.6%
Self-Pay after primary[2]	2.1%	2.9%	0.9%	5.9%
Other	1.8%	0.6%	0.5%	2.9%
Total	78.1%	16.1%	5.8%	100.0%

March 31, 2010	0-90 days	91-180 days	Over 180 days	Total
Medicare	18.3%	0.4%	0.4%	19.1%
Medicaid	5.5%	0.8%	0.8%	7.1%
Managed Medicare	12.1%	0.5%	0.5%	13.1%
Managed Medicaid	7.5%	0.5%	0.5%	8.5%
Managed Care	28.2%	1.6%	1.3%	31.1%
Self-Pay[1]	8.9%	2.7%	0.6%	12.2%
Self-Pay after primary[2]	2.7%	2.4%	0.6%	5.7%
Other	2.1%	0.7%	0.4%	3.2%
Total	85.3%	9.6%	5.1%	100.0%

(1) Includes uninsured patient accounts only.
(2) Includes patient co-insurance and deductible amounts after payment has been received from the primary payer.

Our combined allowances for doubtful accounts, uninsured discounts and charity care covered 96.5% and 87.2% of combined self-pay and self-pay after primary accounts receivable as of June 30, 2009 and March 31, 2010, respectively. The period over period decrease is due to the implementation of our uninsured discount policy at our Phoenix and San Antonio hospitals effective July 1, 2009.

The volume of self-pay accounts receivable remains sensitive to a combination of factors including price increases, acuity of services, higher levels of patient deductibles and co-insurance under managed care plans, economic factors and the increased difficulties of uninsured patients who do not qualify for charity care programs to pay for escalating healthcare costs. We have implemented policies and procedures designed to expedite upfront cash collections and promote repayment plans from our patients. However, we believe bad debts will remain a significant risk for us and the rest of the hospital industry in the near term.

Governmental and Managed Care Payer Reimbursement

Healthcare spending comprises a significant portion of total spending in the United States and has been growing at annual rates that exceed inflation, wage growth and gross national product. There is considerable pressure on governmental payers, managed Medicare/Medicaid payers and commercial managed care payers to control costs by either reducing or limiting increases in reimbursement to healthcare providers or limiting benefits to enrollees. The current weakened economic environment has magnified these pressures. Lower than expected tax collections due to higher unemployment and depressed consumer spending have resulted in budget shortfalls for most states, including those in which we operate. Additionally, the demand for Medicaid coverage has increased due to job losses that have left many individuals without health insurance. To balance their budgets, many states, either directly or through their managed Medicaid programs, may enact healthcare spending cuts or defer cash payments to healthcare providers. Further, the tightened credit markets have complicated the states' efforts to issue additional bonds to raise cash. During the nine months ended March 31, 2010, combined Medicaid and managed Medicaid programs accounted for approximately 17% of our net patient revenues. Managed care payers also face economic pressures during periods of economic weakness due to lower enrollment resulting from higher unemployment rates and the inability of individuals to afford private insurance coverage. These payers may respond to these challenges by reducing or limiting increases to healthcare provider reimbursement rates or reducing benefits to enrollees. During the nine months ended March 31, 2010, we recognized approximately 35% of our net patient revenues from managed care payers. If we do not receive increased payer reimbursement rates from governmental or managed care payers that cover the increasing cost of providing healthcare services to our patients or if governmental payers defer payments to our hospitals, our financial position, results of operations and cash flows could be materially adversely impacted.

Increased Costs of Compliance in a Heavily Regulated Industry

We conduct business in a heavily regulated industry. Accordingly, we maintain a comprehensive, company-wide compliance program to address healthcare regulatory and other compliance requirements. This compliance program includes, among other things, initial and periodic ethics and compliance training, a toll-free reporting hotline for employees, annual fraud and abuse audits and annual coding audits. The organizational structure of our compliance program includes oversight by our board of directors and a high-level corporate management compliance committee. Our Senior Vice President of Compliance and Ethics reports jointly to our Chairman and Chief Executive Officer and to our board of directors, serves as our Chief Compliance Officer and is charged with direct responsibility for the day-to-day management of our compliance program. We also have regional compliance officers in our markets that are 100% dedicated to compliance duties. The financial resources necessary for program oversight, internal enforcement and periodic improvements to our program continue to grow, especially when we add new features to our program or engage external resources to assist with these highly complex matters.

Premium Revenues

We recognize premium revenues from our three health plans, PHP, AAHP and MHP. PHP's membership increased to approximately 200,500 at March 31, 2010 compared to approximately 164,200 at March 31, 2009 primarily due to weakened economic conditions in Arizona that resulted in a greater number of individuals eligible for coverage under Arizona Health Care Cost Containment System ("AHCCCS"). Premium revenues from these three plans increased $147.2 million or 30.6% during the nine months ended March 31, 2010 compared to the prior year period due to the increase in PHP membership and the fact that the current year period reflects a full nine months under PHP's new AHCCCS contract (see discussion below).

In May 2008, PHP was awarded a new contract with AHCCCS effective for the three-year period beginning October 1, 2008 and ending September 30, 2011. AHCCCS has the option to renew the new contract, in whole or in part, for two additional one-year periods commencing on October 1, 2011 and on October 1, 2012. The new contract covers the three counties covered under the previous contract (Gila, Maricopa and Pinal) plus an additional six Arizona counties (Apache, Coconino, Mohave, Navajo, Pima and Yavapai). The new contract utilizes a national episodic/diagnostic risk adjustment factor for non-reconciled enrollee risk groups, which AHCCCS applied retroactively to October 1, 2008, that was not part of PHP's previous AHCCCS contract. Our financial statements include an estimated reserve for the impact of this risk adjustment factor. In response to the State of Arizona's budget crisis and continued concerns about economic indicators during its 2010 fiscal year, AHCCCS has made certain changes to its current contract with PHP that negatively impact PHP's current and future revenues. AHCCCS could take further actions in the near term that could materially adversely impact our operating results and cash flows including reimbursement rate cuts, enrollment reductions, capitation payment deferrals, covered services reductions or limitations or other steps to reduce program expenditures including cancelling PHP's contract.

Critical Accounting Policies

Our condensed consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States. In preparing these financial statements, we make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses included in the financial statements. Management bases its estimates on historical experience and other available information, the results of which form the basis of its estimates and assumptions. We consider the following accounting policies to be critical because they involve highly subjective and complex assumptions, are subject to greater fluctuation and are the most critical to our operating performance.

- Revenues and revenue deductions
- Allowance for doubtful accounts and provision for doubtful accounts
- Insurance reserves
- Health plan claims reserves
- Income taxes
- Long-lived assets and goodwill

There have been no changes in the nature or application of our critical accounting policies during the nine months ended March 31, 2010 when compared to those described in our Current Report on Form 8-K filed with the SEC on January 19, 2010, except those described below.

Revenues and Revenue Deductions

Effective for service dates on or after July 1, 2009, we implemented a new uninsured discount policy for those patients receiving services in our Phoenix and San Antonio hospitals who had no insurance coverage and who did not otherwise qualify for charity care under our guidelines. We implemented this same policy for our Illinois hospitals on April 1, 2009. Under this policy, we apply an uninsured discount (calculated as a standard percentage of gross charges) at the time of patient billing and include this discount as a reduction to patient service revenues. These discounts were approximately $161.0 million for the nine months ended March 31, 2010.

Allowance for Doubtful Accounts and Provision for Doubtful Accounts

We estimate our allowance for doubtful accounts using a standard policy that reserves all accounts aged greater than 365 days subsequent to discharge date plus percentages of uninsured accounts and self-pay after primary accounts less than 365 days old. We test our allowance for doubtful accounts policy quarterly using a hindsight calculation that utilizes write-off data for all payer classes during the previous twelve-month period to estimate the allowance for doubtful accounts at a point in time. We also supplement our analysis by comparing cash collections to net patient revenues and monitoring self-pay utilization. We adjust the standard percentages in our allowance for doubtful accounts reserve policy as necessary given changes in trends from these analyses. We most recently adjusted this reserve policy when we implemented our uninsured discount policy in our Phoenix and San Antonio hospitals on July 1, 2009 and in our Illinois hospitals on April 1, 2009. Significant changes in payer mix, business office operations, general economic conditions and healthcare coverage provided by federal or state governments or private insurers may have a significant impact on our estimates and significantly affect our liquidity, results of operations and cash flows.

Prior to the implementation of our new uninsured discount policy, we classified accounts pending Medicaid approval as Medicaid accounts in our accounts receivable aging report and recorded a contractual discount for these accounts based upon the average Medicaid reimbursement rate for that specific state until qualification was confirmed. In the event an account did not successfully qualify for Medicaid coverage and did not meet our charity guidelines, the previously recorded Medicaid contractual adjustment remained a revenue deduction (similar to a self-pay discount), and the remaining net account balance was reclassified to uninsured status and subjected to our allowance for doubtful accounts policy. If accounts did not qualify for Medicaid coverage but did qualify as charity care, the contractual adjustments were reversed and the gross account balances were recorded as charity deductions.

Upon the implementation of our new uninsured discount policy in our Phoenix, San Antonio and Illinois hospitals, all uninsured accounts (including those pending Medicaid qualification) that do not qualify for charity care receive the standard uninsured discount. The balance of these accounts is subject to our allowance for doubtful accounts policy. For those accounts that subsequently qualify for Medicaid coverage, the uninsured discount is reversed and the account is reclassified

to Medicaid accounts receivable with the appropriate contractual discount applied. Thus, the contractual allowance for Medicaid pending accounts is no longer necessary for those accounts subject to the uninsured discount policy.

Long-Lived Assets and Goodwill

Both long-lived assets, including property, plant and equipment and amortizable intangible assets, and goodwill comprise a significant portion of our total assets. We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist. When management believes impairment indicators may exist, projections of the undiscounted future cash flows associated with the use of and eventual disposition of long-lived assets held for use are prepared. If the projections indicate that the carrying values of the long-lived assets are not recoverable, we reduce the carrying values to fair value.

We review goodwill for impairment annually during our fourth fiscal quarter or more frequently if certain impairment indicators arise. We review goodwill at the reporting level unit, which is one level below an operating segment. We compare the carrying value of the net assets of each reporting unit to the net present value of estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied.

Our two Illinois hospitals have experienced deteriorating economic factors that have negatively impacted their results of operations and cash flows. While various initiatives mitigated the impact of these economic factors during fiscal years 2008 and 2009, the operating results of the Illinois hospitals did not improve to the level anticipated during the first half of fiscal 2010. After having the opportunity to evaluate the operating results of the Illinois hospitals for the first six months of fiscal year 2010 and to reassess the market trends and economic factors, we concluded that it was unlikely that previously projected cash flows for these hospitals would be achieved. We performed an interim goodwill impairment test during the quarter ended December 31, 2009 and, based upon revised projected cash flows, market participant data and appraisal information, we determined that the $43.1 million remaining goodwill related to this reporting unit was impaired. We recorded the $43.1 million ($31.8 million, net of taxes) non-cash impairment loss in our condensed consolidated statement of operations for the quarter ended December 31, 2009.

Selected Operating Statistics

The following table sets forth certain operating statistics for each of the periods presented.

	Quarter ended March 31,		Nine months ended March 31,	
	2009	2010	2009	2010
Number of hospitals at end of period	15	15	15	15
Number of licensed beds at end of period	4,135	4,135	4,135	4,135
Discharges (a)	42,595	42,293	126,480	126,211
Adjusted discharges - hospitals (a)	69,460	69,646	205,510	208,763
Adjusted discharges (a)	73,221	73,678	216,489	220,881
Net revenue per adjusted discharge - hospitals (a)	$ 8,997	$ 8,737	$ 8,634	$ 8,502
Net revenue per adjusted discharge (a)	$ 9,054	$ 8,636	$ 8,544	$ 8,422
Patient days (a)	182,872	180,672	536,930	528,877
Average length of stay (days) (a)	4.29	4.27	4.25	4.19
Inpatient surgeries (a)	9,578	9,188	28,440	28,076
Outpatient surgeries (a)	18,931	18,425	56,857	56,885
Emergency room visits (a)	156,940	154,987	446,793	465,714
Occupancy rate (a)	49.1%	48.5%	47.4%	46.7%
Member lives (a)	207,400	240,300	207,400	240,300
Health plan claims expense percentage (a)	78.6%	79.5%	77.1 %	79.6%

(a) The definitions for the statistics included above are set forth in Part 2, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations", "Selected Operating Statistics" in our Report on Form 8-K filed with the SEC on January 19, 2010.

Results of Operations

The following table presents summaries of our operating results for the quarters and nine months ended March 31, 2009 and 2010.

	Quarter ended March 31,			
	2009		2010	
	Amount	%	Amount	%
	(In millions)			
Patient service revenues	$ 676.1	78.8%	$ 649.8	75.5%
Premium revenues	181.9	21.2%	211.4	24.5%
Total revenues	858.0	100.0%	861.2	100.0%
Salaries and benefits (includes stock compensation of $1.2 and $0.6, respectively)	328.4	38.3%	328.7	38.2%
Health plan claims expense	143.0	16.7%	168.1	19.5%
Supplies	115.3	13.4%	114.1	13.2%
Provision for doubtful accounts	52.5	6.1%	40.7	4.7%
Other operating expenses	133.8	15.6%	120.1	14.0%
Depreciation and amortization	31.6	3.7%	34.6	4.0%
Interest, net	27.2	3.2%	29.9	3.5%
Debt extinguishment costs	–	0.0%	73.2	8.5%
Other	1.2	0.1%	0.9	0.1%
Income (loss) from continuing operations before income taxes	25.0	2.9%	(49.1)	(5.7)%
Income tax benefit (expense)	(8.2)	(1.0)%	16.5	1.9%
Income (loss) from continuing operations	16.8	1.9%	(32.6)	(3.8)%
Income (loss) from discontinued operations, net of taxes	(0.3)	0.0%	0.2	0.0%
Net income (loss)	16.5	1.9%	(32.4)	(3.8)%
Less: Net income attributable to non-controlling interests	(0.7)	(0.1)%	(0.4)	(0.0)%
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 15.8	1.8%	$ (32.8)	(3.8)%

	Nine months ended March 31,			
	2009		2010	
	Amount	%	Amount	%
	(In millions)			
Patient service revenues	$ 1,888.8	79.7%	$ 1,900.2	75.2%
Premium revenues	480.8	20.3%	628.0	24.8%
Total revenues	2,369.6	100.0%	2,528.2	100.0%
Salaries and benefits (includes stock compensation of $3.4 and $3.5, respectively)	923.7	39.0%	967.6	38.3%
Health plan claims expense	370.7	15.6%	499.9	19.8%
Supplies	339.9	14.3%	339.9	13.4%
Provision for doubtful accounts	155.4	6.6%	112.9	4.5%
Other operating expenses	355.4	15.0%	368.8	14.6%
Depreciation and amortization	96.0	4.0%	102.9	4.1%
Interest, net	84.5	3.6%	84.6	3.3%
Impairment loss	–	0.0%	43.1	1.7%
Debt extinguishment costs	–	0.0%	73.2	2.9%
Other expenses	2.0	0.1%	3.5	0.1%
Income (loss) from continuing operations before income taxes	42.0	1.8%	(68.2)	(2.7)%
Income tax benefit (expense)	(13.5)	(0.6)%	18.2	0.7%
Income (loss) from continuing operations	28.5	1.2%	(50.0)	(2.0)%
Income from discontinued operations, net of taxes	0.6	0.0%	0.1	0.0%
Net income (loss)	29.1	1.2%	(49.9)	(2.0)%
Less: Net income attributable to non-controlling interests	(2.3)	(0.1)%	(2.1)	(0.1)%
Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders	$ 26.8	1.1%	$ (52.0)	(2.1)%

Quarter ended March 31, 2010 compared to quarter ended March 31, 2009

Revenues. Total revenues were basically flat during the quarter ended March 31, 2010 compared to the prior year quarter. Patient service revenues decreased $26.3 million during the current year quarter primarily due to the implementation of our uninsured discount policy in our Illinois hospitals effective April 1, 2009 and in our Phoenix and San Antonio hospitals effective July 1, 2009 combined with the concurrent change to our Medicaid pending policy previously discussed. During the current year quarter, we recognized $48.1 million of uninsured discount revenue deductions, $30.6 million of which would have otherwise been included in revenues and subjected to our allowance for doubtful accounts policy had the uninsured discount policy not been implemented at these hospitals. Additionally, during the prior year quarter we received an $18.7 million retroactive payment under the newly implemented Illinois Provider Tax Assessment program, $12.4 million of which related to prior quarters. Health plan premium revenues increased $29.5 million during the current year quarter as a result of increased PHP enrollment. Average enrollment at PHP was 199,568 during the quarter ended March 31, 2010, an increase of 22.9% compared to the prior year quarter. More challenging economic conditions in Arizona since the prior year quarter resulted in more individuals becoming eligible for AHCCCS coverage. Enrollment in our other two health plans decreased by 7.9% during the current year quarter compared to the prior year quarter.

Adjusted discharges increased 0.6% during the quarter ended March 31, 2010 compared to the prior year quarter, while discharges, total surgeries and emergency room visits decreased by 0.7%, 3.1% and 1.2%, respectively, during the current year quarter. Two new competitor hospitals in San Antonio opened in March 2009 and July 2009, which negatively impacted volumes in certain of our San Antonio hospitals during the current year quarter. We continue to face volume and pricing pressures as a result of continuing economic weakness in the communities our hospitals serve, state efforts to reduce Medicaid program expenditures and intense competition for limited physician and nursing resources, among other factors. We expect the average population growth in the markets we serve to remain generally high in the long-term. As these populations increase and grow older, we believe that our clinical quality initiatives will improve our competitive position in those markets. However, these growth opportunities may not overcome the current industry and market challenges in the short-term.

We continue to implement multiple initiatives to transform our company's operations to prepare for the future changes we expect to occur in the healthcare industry. This transformation process is built upon providing ideal experiences for our patients and their families through clinical excellence, aligning nursing and physician interests to provide coordination of care and improving healthcare delivery efficiencies to provide quality outcomes without overutilization of resources. The success of these initiatives will determine our ability to increase revenues from our existing operations and to increase revenues through acquisitions of other hospitals.

Costs and Expenses. Total costs and expenses from continuing operations, exclusive of income taxes, were $910.3 million or 105.7% of total revenues during the current year quarter, compared to 97.1% during the prior year quarter. This ratio was negatively impacted by $73.2 million of debt extinguishment costs incurred as a result of our comprehensive refinancing transactions during the current year quarter as further discussed in "Liquidity and Capital Resources" presented elsewhere in this report. Salaries and benefits, health plan claims, supplies and provision for doubtful accounts represent the most significant of our normal costs and expenses and those typically subject to the greatest level of fluctuation period over period.

- **Salaries and benefits**. Salaries and benefits as a percentage of total revenues was not significantly different during the current year quarter compared to the prior year quarter. This ratio was positively impacted by the significant increase in premium revenues, which utilize a much lower percentage of salaries and benefits than acute care services, during the current year quarter compared to the prior year quarter. For the acute care services operating segment, salaries and benefits as a percentage of patient service revenues was 48.5% during the current year quarter compared to 46.8% during the prior year quarter. This increase was primarily due to the impact to patient service revenues of changes to our uninsured discount and Medicaid pending policies previously discussed. We continue to employ more physicians to support the communities our hospitals serve and have made significant investments in clinical quality initiatives that will require additional human resources in the short-term. As of March 31, 2010, we had approximately 19,800 full-time and part-time employees compared to approximately 19,100 as of March 31, 2009. We have been successful in limiting contract labor utilization as a result of our investments in clinical quality and nurse leadership initiatives.

- **Health plan claims.** Health plan claims expense as a percentage of premium revenues increased to 79.5% during the current year quarter compared to 78.6% during the prior year quarter. As enrollment increases, this ratio becomes especially sensitive to the mix of enrollees, including covered groups based upon age and gender and county of residence. AHCCCS also implemented limits on profitability for certain enrollee groups during the current contract year, which negatively impacted this ratio. In addition, the increased PHP revenues diluted the impact of the third party administrator revenues at MHP that have no corresponding health plan claims expense. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $10.7 million, or 6.0% of gross health plan claims expense, were eliminated in consolidation during the current year quarter.

- **Supplies.** Supplies as a percentage of patient service revenues increased to 17.6% during the current year quarter compared to 17.1% during the prior year quarter. This ratio would have improved during the current year quarter absent the impact to patient service revenues of the changes to our uninsured discount and Medicaid pending policies previously discussed. We continued our focus on supply chain efficiencies including reduction in physician commodity variation and improved pharmacy formulary management during the current year quarter. Our ability to reduce this ratio in future periods may be limited because our growth strategies include expansion of higher acuity services and due to inflationary pressures on medical supplies and pharmaceuticals.

- **Provision for doubtful accounts.** The provision for doubtful accounts as a percentage of patient service revenues decreased to 6.3% during the current year quarter from 7.8% during the prior year quarter. Substantially all of this decrease related to the uninsured discount policy and Medicaid pending policy changes previously discussed. The net impact of these policy changes resulted in the recognition of a significant amount of uninsured revenue deductions that would have otherwise been reflected in the provision for doubtful accounts absent these changes. On a combined basis, the provision for doubtful accounts, charity care deductions and uninsured discounts as a percentage of acute care services segment revenues (prior to these revenue deductions) was 10.5% and 15.0% for the prior year and current year quarters, respectively. The uninsured discount and Medicaid pending policy changes resulted in an approximate 250 basis point increase in this ratio during the current year quarter. The remainder of the increase related to an increase in self-pay discharges during the current year quarter (after adjusting for the Medicaid pending policy change) and price increases.

Other operating expenses. Other operating expenses as a percentage of total revenues decreased to 14.0% during the current year quarter compared to 15.6% during the prior year period. This decrease was primarily due to $11.9 million of additional insurance expense recognized during the prior year quarter related to a significant professional liability verdict against one of our hospitals. We initially appealed this verdict, but during the current year quarter we settled this case and paid the settlement amount.

Income taxes. Our effective tax rate was approximately 33.6% during the current year quarter compared to 32.8% during the prior year quarter.

Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders. Net loss attributable to Vanguard stockholders was $32.8 million during the current year quarter compared to net income attributable to Vanguard Health Systems, Inc. stockholders of $15.8 million during the prior year quarter. This change resulted primarily from the debt extinguishment costs recognized during the current year quarter associated with the refinancing transactions.

Nine months ended March 31, 2010 compared to nine months ended March 31, 2009

Revenues. Total revenues increased $158.6 million or 6.7% during the nine months ended March 31, 2010 compared to the prior year period primarily due to a significant increase in health plan premium revenues as a result of increased PHP enrollment. Average enrollment at PHP was 193,687 during the nine months ended March 31, 2010, an increase of 35.2% compared to the prior year period. The new AHCCCS contract that went into effect on October 1, 2008 included six new counties that PHP had not previously served. The new contract was in effect for the entire nine-month period ended March 31, 2010 but only in effect for six months of the nine-month period ended March 31, 2009.

Patient service revenues increased $11.4 million or 0.6% during the nine months ended March 31, 2010 compared to the prior year period. This small increase compared to larger increases from previous periods resulted from the implementation of our uninsured discount policy as previously discussed. During the current year period, we recognized $161.0 million of uninsured discount revenue deductions, $95.2 million of which would have otherwise been included in revenues and subjected to our allowance for doubtful accounts policy had the uninsured discount policy not been implemented at these hospitals. Adjusted discharges increased 2.0%, total surgeries decreased 0.4% and emergency room visits increased 4.2% during the current year period compared to the prior year period, respectively. Net revenue per adjusted discharge decreased 1.4% during the current year period compared to the prior year period primarily due to the implementation of the previously discussed uninsured discount and Medicaid pending policy changes.

Costs and Expenses. Total costs and expenses from continuing operations, exclusive of income taxes, were $2,596.4 million or 102.7% of total revenues during the current year period, compared to 98.2% during the prior year period. This ratio was adversely impacted by the $43.1 million ($31.8 million, net of taxes) goodwill impairment loss related to our Chicago hospitals reporting unit and the $73.2 million of debt extinguishment costs related to refinancing transactions during the current year period. Salaries and benefits, health plan claims, supplies and provision for doubtful accounts represent the most significant of our normal costs and expenses and those typically subject to the greatest level of fluctuation period over period.

- **Salaries and benefits**. Salaries and benefits as a percentage of total revenues decreased to 38.3% during the current year period from 39.0% during the prior year period. This ratio was positively impacted by the significant increase in premium revenues, which utilize a much lower percentage of salaries and benefits than acute care services, during the current year period compared to the prior year period. For the acute care services operating segment, salaries and benefits as a percentage of patient service revenues was 48.8% during the current year period compared to 47.1% during the prior year period. This increase was primarily due to the impact to patient service revenues of changes to our uninsured discount and Medicaid pending policies previously discussed.

- **Health plan claims**. Health plan claims expense as a percentage of premium revenues increased to 79.6% during the current year period compared to 77.1% during the prior year period. The new PHP contract with AHCCCS that went into effect on October 1, 2008 resulted in a significant change in the mix of our enrollees with a significant increase in enrollees in geographic areas not previously served by PHP. As a result of the bid process for these new areas, the rates paid to providers in those six new counties and capitated payment rates received from AHCCCS for those counties were not necessarily the same as those applicable to the three counties served by PHP under its previous contract. The implementation by AHCCCS of the national episodic risk adjustment factor payment methodology for certain enrollees and the dilution of the third party administrator revenues at MHP also adversely impacted this ratio during the current year period. Revenues and expenses between the health plans and our hospitals and related outpatient service providers of approximately $31.7 million, or 6.0% of gross health plan claims expense, were eliminated in consolidation during the current year period.

- **Supplies**. Supplies as a percentage of patient service revenues decreased to 17.9% during the current year period compared to 18.0% during the prior year period. This ratio was negatively impacted during the current year period by the changes to our uninsured discount and Medicaid pending policies previously discussed. We recognized improvements in this ratio during the current year period primarily due to our continued focus on supply chain efficiencies including reduction in physician commodity variation and improved pharmacy formulary management.

- **Provision for doubtful accounts**. The provision for doubtful accounts as a percentage of patient service revenues decreased to 5.9% during the current year period from 8.2% during the prior year period. Substantially all of this decrease related to the uninsured discount policy and Medicaid pending policy changes previously discussed. The net impact of these policy changes resulted in the recognition of a significant amount of uninsured revenue deductions that would have otherwise been reflected in the provision for doubtful accounts absent these changes. On a combined basis, the provision for doubtful accounts, charity care deductions and uninsured discounts as a percentage of acute care services segment revenues (prior to these revenue deductions) was 11.4% and 15.7% for the prior year and current year periods, respectively. The uninsured discount and Medicaid pending policy changes resulted in an approximate 350 basis point increase in this ratio during the current year period. The remainder of this

increase primarily related to a 3.9% increase in self-pay discharges during the current year period (after adjusting for the Medicaid pending policy change).

Other operating expenses. Other operating expenses as a percentage of total revenues decreased to 14.6% during the current year period compared to 15.0% during the prior year period. Other operating expenses as a percentage of patient service revenues increased to 19.4% during the current year period compared to 18.8% during the prior year period. This increase was primarily due to the impact to patient service revenues of our uninsured discount and Medicaid pending policy changes previously discussed.

Income taxes. Our effective tax rate decreased to approximately 26.7% during the current year period compared to 32.2% during the prior year period. The effective rate was lower during the current year period due to the fact that a considerable portion of the goodwill impairment loss related to our Chicago hospitals reporting unit, as previously discussed, was non-deductible for tax purposes.

Net income (loss) attributable to Vanguard Health Systems, Inc. stockholders. Net loss attributable to Vanguard Health Systems, Inc. stockholders was $52.0 million during the current year period compared to net income attributable to Vanguard Health Systems, Inc. stockholders of $26.8 million during the prior year period. This change resulted primarily from the goodwill impairment loss and the debt extinguishment costs related to the refinancing transactions recognized during the current year period.

Liquidity and Capital Resources

Operating Activities

At March 31, 2010, we had working capital of $106.6 million, including cash and cash equivalents of $210.3 million. Working capital at June 30, 2009 was $251.6 million. The significant decrease in period over period working capital primarily relates to the $300.6 million share repurchase made in connection with the refinancing transactions described below. Cash provided by operating activities decreased $32.7 million during the nine months ended March 31, 2010 compared to the prior year period. This decrease was primarily attributable to a slower enrollment growth rate at PHP and related slower buildup of accrued health plan claims during the current year period compared to the prior year period and the settlement and payment of a significant professional liability case during the current year period. Net accounts receivable days was 45 days at March 31, 2010, compared to 45 days at June 30, 2009 and 47 days at March 31, 2009.

Investing Activities

Cash used in investing activities increased from $91.3 million during the prior year period to $111.4 million during the current year period, primarily as a result of a $23.8 million increase in capital expenditures during the current year period compared to the prior year period. We anticipate spending a total of $165.0 million to $175.0 million in capital expenditures during fiscal 2010, including the $111.1 million already spent through March 31, 2010.

Financing Activities

Cash flows used in financing activities increased $195.7 million during the current year period compared to the prior year period primarily due to the current year period $300.6 million share repurchase less the $103.8 million net debt proceeds from the refinancing transactions (debt borrowings less debt repayments and the payment of related fees and expenses). As of March 31, 2010, we had outstanding $1,751.6 million in aggregate indebtedness. The "Refinancing" section below provides additional information related to our liquidity.

The Refinancing

In late January 2010, we completed a comprehensive refinancing plan (the "Refinancing"). As a result of the Refinancing, our liquidity requirements remain significant due to debt service requirements. Under the Refinancing, we entered into an $815.0 million senior secured term loan (the "2010 term loan facility") and a $260.0 million revolving credit facility (the "2010 revolving facility" and together with the 2010 term loan facility, the "2010 credit facilities"). The 2010 term loan facility matures in January 2016 and bears interest at a per annum rate equal to, at our option, LIBOR (subject to a floor of 1.50%) plus 3.50% or a base rate plus 2.50%. Upon the occurrence of certain events, we may request an incremental

term loan facility to be added to the 2010 term loan facility to issue additional term loans in such amount as we determine, subject to the receipt of commitments by existing lenders or other financial institutions for such amount of term loans and the satisfaction of certain other conditions. The 2010 revolving facility matures in January 2015, and we may seek to increase the borrowing availability under the 2010 revolving facility to an amount larger than $260.0 million, subject to the receipt of commitments by existing lenders or other financial institutions for such increased revolving facility and the satisfaction of other conditions. Borrowings under the 2010 revolving facility bear interest at a per annum rate equal to, at our option, LIBOR plus 3.50% or a base rate plus 2.50%, both of which are subject to a 0.25% decrease dependent upon our consolidated leverage ratio. We may utilize the 2010 revolving facility to issue up to $100.0 million of letters of credit ($30.2 million of which were outstanding as of March 31, 2010).

Under the Refinancing, we issued $815.0 million in term loans under the 2010 term loan facility and $950.0 million aggregate amount at maturity ($936.3 million cash proceeds) of 8.0% senior unsecured notes due February 2018 in a private placement offering (the "8.0% Notes"). The 8.0% Notes are redeemable, in whole or in part, at any time on or after February 1, 2014 at specified redemption prices. On or after February 1, 2014, we may redeem all or part of the 8.0% Notes at various redemption prices given the date of redemption as set forth in the indenture governing the 8.0% Notes. In addition, we may redeem up to 35% of the 8.0% Notes prior to February 1, 2013 with the net cash proceeds from certain equity offerings at a price equal to 108% of their principal amount, plus accrued and unpaid interest. We may also redeem some or all of the 8.0% Notes before February 1, 2014 at a redemption price equal to 100% of the principal amount thereof, plus a "make-whole" premium and accrued and unpaid interest.

The proceeds from the 2010 credit facilities, the issuance of the 8.0% Notes and available cash were used to repay the $764.2 million principal and interest outstanding related to our 2005 term loan facility; to fund $597.0 million and $232.5 million of cash tender offers and consent solicitations and accrued interest for those holders of the 9.0% Notes and 11.25% Notes, respectively, who accepted the tender offers; to pay $26.9 million to redeem those 9.0% Notes and 11.25% Notes not previously tendered including such principal, interest and call premiums; to pay fees and expenses related to the Refinancing of $90.1 million; to pay $1.7 million to terminate our interest rate swap agreement related to our 2005 term loan facility representing the swap liability at the Refinancing date; to purchase 446 shares held by certain former employees for $0.6 million; and to fund a $300.0 million distribution to repurchase a portion of the shares owned by the remaining stockholders. Subsequent to the $300.0 million share repurchase, we completed a 1.4778 for one split that effectively returned the share ownership for each stockholder that participated in the distribution to the same level as that in effect immediately prior to the distribution.

Debt Covenants

Our 2010 credit facilities contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability, and the ability of our subsidiaries, to sell assets, incur additional indebtedness or issue preferred stock, repay other indebtedness (including the 8.0% Notes), pay dividends and distributions or repurchase our capital stock, create liens on assets, make investments, loans or advances, make certain acquisitions, engage in mergers or consolidations, create a healthcare joint venture, engage in certain transactions with affiliates, amend certain material agreements governing our indebtedness, including the 8.0% Notes, change the business conducted by our subsidiaries, enter into certain hedging agreements and make capital expenditures above specified levels. In addition, the 2010 credit facilities include the following additional financial covenants: a maximum consolidated leverage ratio and a minimum consolidated interest coverage ratio. The following table sets forth the leverage and interest coverage covenant requirements for the next 5 required test periods.

	Consolidated Leverage Ratio	Consolidated Interest Coverage Ratio
June 30, 2010	6.25x	2.00x
September 30, 2010	6.25x	2.00x
December 31, 2010	6.25x	2.00x
March 31, 2011	6.25x	2.00x
June 30, 2011	5.95x	2.10x

If we had been required to comply with these debt covenants as of March 31, 2010, our consolidated leverage ratio would have been 4.75x and our consolidated interest coverage ratio would have been 2.68x.

Factors outside our control may make it difficult for us to comply with these covenants during future periods. These factors include a prolonged economic recession, a higher number of uninsured or underinsured patients and decreased governmental or managed care payer reimbursement, among others, any or all of which could negatively impact our results of operations and cash flows and cause us to violate one or more of these covenants. Violation of one or more of the covenants could result in an immediate call of the outstanding principal amount under our 2010 term loan facility or the necessity of lender waivers with more onerous terms including adverse pricing or repayment provisions or more restrictive covenants. A default under our 2010 credit facilities would also result in a default under the Indenture governing our 8.0% Notes.

Credit Ratings

The table below summarizes our credit ratings as of the date of this filing.

	Standard & Poor's	Moody's
Corporate credit rating	B	B2
8.0% Notes	CCC+	B3
2010 credit facilities	B+	Ba2

Our credit ratings are subject to periodic reviews by the ratings agencies. If our results of operations deteriorate either as a result of the weakness in the current U.S. economy or other factors, any or all of our corporate ratings may be downgraded. A credit rating downgrade could further impede our ability to refinance all or a portion of our outstanding debt.

Capital Resources

We expect that cash on hand, cash generated from our operations and cash expected to be available to us under our 2010 credit facilities will be sufficient to meet our working capital needs, debt service requirements and planned capital expenditure programs during the next twelve months and into the foreseeable future. However, we cannot assure you that our operations will generate sufficient cash or that additional future borrowings under our senior credit facilities will be available to enable us to meet these requirements, especially given the current volatility in the credit markets and general economic weakness.

We had $210.3 million of cash and cash equivalents as of March 31, 2010. We rely on available cash, cash flows generated by operations and available borrowing capacity under our 2010 revolving facility to fund our operations and capital expenditures. We invest our cash in accounts in high-quality financial institutions. We continually explore various options to increase the return on our invested cash while preserving our principal cash balances. However, the significant majority of our cash and cash equivalents are not federally-insured and could be at risk in the event of a collapse of those financial institutions.

At March 31, 2010, we held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on our condensed consolidated balance sheet due to inactivity in the primary ARS market during the past year. The par value of the ARS was $26.3 million as of March 31, 2010.

We also intend to continue to pursue acquisitions or partnering arrangements, either in existing markets or new markets, which fit our growth strategies including the DMC letter of intent previously discussed and other potential transactions. To finance such transactions, we expect to increase borrowings under our 2010 term loan facility and may draw upon cash on hand, utilize amounts available under our 2010 revolving facility or seek additional equity funding. We continually assess our capital needs and may seek additional financing, including debt or equity, as considered necessary to fund potential acquisitions, fund capital projects or for other corporate purposes. However, we may be unable to raise additional equity proceeds from Blackstone or other investors should we need to obtain cash for any of these purposes. Our future operating performance, ability to service our debt and ability to draw upon other sources of capital will be subject to future economic conditions and other business factors, many of which are beyond our control.

Obligations and Commitments

The following table reflects a summary of obligations and commitments outstanding, including both the principal and interest portions of long-term debt, with payment dates as of March 31, 2010.

	Payments due by period				
	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Contractual Cash Obligations:			*(In millions)*		
Long-term debt (1)	$ 111.1	$ 296.3	$ 293.6	$ 2,052.0	$ 2,753.0
Operating leases (2)	30.5	46.1	30.3	35.6	142.5
Purchase obligations (2)	36.2	–	–	–	36.2
Health plan claims payable (3)	141.7	–	–	–	141.7
Estimated self-insurance liabilities (4)	38.6	41.0	24.1	14.0	117.7
Subtotal	$ 358.1	$ 383.4	$ 348.0	$ 2,101.6	$ 3,191.1

	Within 1 year	During Years 2-3	During Years 4-5	After 5 years	Total
Other Commitments:			*(In millions)*		
Construction and capital improvements (5)	$ 61.1	$ 11.6	$ –	$ –	$ 72.7
Guarantees of surety bonds (6)	50.0	–	–	–	50.0
Letters of credit (7)	–	–	30.2	–	30.2
Physician commitments (8)	4.0	–	–	–	4.0
Estimated net liability for uncertain tax positions (9)	0.4	–	–	–	0.4
Subtotal	$ 115.5	$ 11.6	$ 30.2	$ –	$ 157.3
Total obligations and commitments	$ 473.6	$ 395.0	$ 378.2	$ 2,101.6	$ 3,348.4

(1) Includes both principal and interest payments. The interest portion of our debt outstanding at March 31, 2010 assumes an average interest rate of 8.0%.

(2) These obligations are not reflected in our condensed consolidated balance sheets.

(3) Represents estimated payments to be made in future periods for healthcare costs incurred by enrollees in PHP, AAHP and MHP and is separately stated on our condensed consolidated balance sheets.

(4) Includes the current and long-term portions of our professional and general liability, workers' compensation and employee health reserves.

(5) Represents our estimate of amounts we are committed to fund in future periods through executed agreements to complete projects included as construction in progress on our condensed consolidated balance sheets.

(6) Represents performance bonds we have purchased related to health claims liabilities of PHP.

(7) Amounts relate primarily to instances in which we have letters of credit outstanding with the third party administrator of our self-insured workers' compensation program.

(8) Includes physician guarantee liabilities recognized in our condensed consolidated balance sheets under the guidance of accounting for guarantees and liabilities for other fixed expenses under physician relocation agreements not yet paid.

(9) Represents expected future tax liabilities recognized in our condensed consolidated balance sheets determined under the guidance of accounting for income taxes.

Item 3. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk from exposure to changes in interest rates based on our financing, investing and cash management activities. As of March 31, 2010, we had in place $1,075.0 million of indebtedness bearing interest at variable rates at specified margins above either the agent bank's alternate base rate or the LIBOR rate.

Our 2010 credit facilities consist of $815.0 million in term loans maturing in January 2016 and a $260.0 million revolving credit facility maturing in January 2015 (of which $30.2 million of capacity was utilized by outstanding letters of credit as of March 31, 2010). Although changes in the alternate base rate or the LIBOR rate would affect the cost of funds borrowed in the future, we believe the effect, if any, of reasonably possible near-term changes in interest rates would not be material to our results of operations or cash flows. An estimated 0.25% change in the variable interest rate under our 2010 term loan facility would result in a change in annual net interest of approximately $2.0 million.

Our $260.0 million revolving credit facility bears interest at the alternate base rate plus a margin ranging from 2.25%-2.50% per annum or the LIBOR rate plus a margin ranging from 3.25%-3.50% per annum, in each case dependent upon our consolidated leverage ratio. Our $815.0 million in outstanding term loans bear interest at the alternate base rate plus a margin of 2.50% per annum or the LIBOR rate (subject to a 1.50% floor) plus a margin of 3.50% per annum. We may request an incremental term loan facility to be added to our 2010 term loan facility in an unlimited amount, subject to receipt of commitments by existing lenders or other financing institutions and the satisfaction of certain other conditions. We may also seek to increase the borrowing availability under the 2010 revolving facility to an unlimited amount subject to the receipt of commitments by existing lenders or other financial institutions and the satisfaction of other conditions.

At March 31, 2010, we held $21.6 million in total available for sale investments in auction rate securities ("ARS") backed by student loans, which are included in long-term investments in auction rate securities on our condensed consolidated balance sheets. The par value of the ARS was $26.3 million as of March 31, 2010. We recorded a realized loss on the ARS of $0.6 million and temporary impairments totaling $4.1 million ($2.5 million, net of taxes) related to all $26.3 million par value ARS during our fiscal year ended June 30, 2009. The temporary impairments related to the ARS are included in accumulated other comprehensive loss on our condensed consolidated balance sheet as of March 31, 2010.

Our ARS were rated "AAA" by one or more major credit rating agencies at March 31, 2010 based on their most recent ratings update. The ratings take into account insurance policies guaranteeing both the principal and accrued interest of the investments. The U.S. government guarantees approximately 96%-98% of the principal and accrued interest on each investment in student loans under the Federal Family Education Loan Program or similar programs.

We will continue to monitor market conditions for this type of ARS to ensure that our classification and fair value estimate remain appropriate. Should market conditions in future periods warrant a reclassification or other than temporary impairment of our ARS, we do not believe our financial position, results of operations, cash flows or compliance with debt covenants would be materially impacted. We believe that we currently have adequate working capital to fund operations during the near future based on access to cash and cash equivalents, expected operating cash flows and availability under our revolving credit facility. We do not expect that our holding of the ARS until market conditions improve will significantly adversely impact our operating cash flows.

Item 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Changes in Internal Control Over Financial Reporting

There were no changes in our internal control over financial reporting during our fiscal quarter ended March 31, 2010, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II
OTHER INFORMATION

Item 1A. Risk Factors.

There have not been any material changes to the risk factors previously disclosed in our Annual Report on Form 10-K for the fiscal year ended June 30, 2009, other than the changes set forth in the new or revised risk factors set forth below.

Risks Related to Our Indebtedness

Our high level of debt and significant leverage may adversely affect our operations and our ability to grow and otherwise execute our business strategy.

On January 29, 2010, we completed a comprehensive refinancing plan (the "Refinancing"). Under the Refinancing, we entered into an $815.0 million senior secured term loan maturing in January 2016 (the "New Term Loan Credit Facility") and a $260.0 million revolving credit facility expiring in January 2015 (the "New Revolving Credit Facility" and together with the New Term Loan Credit Facility, the "New Credit Facilities"). Under the Refinancing, we also issued $950.0 million aggregate amount at maturity ($936.3 million cash proceeds) of 8.0% senior unsecured notes due February 2018 in a private placement offering.

We continue to have substantial indebtedness after the Refinancing. As of March 31, 2010, we had $1,751.6 million of outstanding debt, excluding letters of credit and guarantees. As of March 31, 2010, we also have $229.8 million of secured indebtedness available for borrowing under the New Revolving Credit Facility, after taking into account $30.2 million of outstanding letters of credit. In addition, we may request an incremental term loan facility to be added to the New Term Loan Credit Facility to issue additional term loans in such amounts as we determine subject to the receipt of lender commitments and subject to certain other conditions. Similarly, we may seek to increase the borrowing availability under the New Revolving Credit Facility to an amount larger than $260.0 million, subject to the receipt of lender commitments and subject to certain other conditions. The amount of our outstanding indebtedness is substantial compared to the net book value of our assets.

Our substantial indebtedness could have important consequences, including the following:

- our high level of indebtedness could make it more difficult for us to satisfy our obligations with respect to the exchange notes, including any repurchase obligations that may arise thereunder;
- limit our ability to obtain additional financing to fund future capital expenditures, working capital, acquisitions or other needs;
- increase our vulnerability to general adverse economic, market and industry conditions and limit our flexibility in planning for, or reacting to, these conditions;
- make us vulnerable to increases in interest rates since all of our borrowings under our New Credit Facilities are, and additional borrowings may be, at variable interest rates;
- our flexibility to adjust to changing market conditions and ability to withstand competitive pressures could be limited, and we may be more vulnerable to a downturn in general economic or industry conditions or be unable to carry out capital spending that is necessary or important to our growth strategy and our efforts to improve operating margins;
- limit our ability to use operating cash in other areas of our business because we must use a substantial portion of these funds to make principal and interest payments; and
- limit our ability to compete with others who are not as highly-leveraged.

Our ability to make scheduled payments of principal and interest or to satisfy our other debt obligations, to refinance our indebtedness or to fund capital expenditures will depend on our future operating performance. Prevailing economic

conditions (including interest rates) and financial, business and other factors, many of which are beyond our control, will also affect our ability to meet these needs. We may not be able to generate sufficient cash flows from operations or realize anticipated revenue growth or operating improvements, or obtain future borrowings in an amount sufficient to enable us to pay our debt, or to fund our other liquidity needs. We may need to refinance all or a portion of our debt on or before maturity. We may not be able to refinance any of our debt when needed on commercially reasonable terms or at all.

A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. A significant portion of our indebtedness then may become immediately due and payable. We are not certain whether we would have, or be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay in full such indebtedness and our other indebtedness.

Despite our current leverage, we may still be able to incur substantially more debt. This could further exacerbate the risks that we and our subsidiaries face.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of the indenture governing our 8.0% senior unsecured notes and the New Credit Facilities do not fully prohibit us or our subsidiaries from doing so. Our New Revolving Credit Facility provides commitments of up to $260.0 million (not giving effect to any outstanding letters of credit, which would reduce the amount available under our New Revolving Credit Facility), of which $229.8 million is available for future borrowings as of March 31, 2010. In addition, we may seek to increase the borrowing availability under the New Revolving Credit Facility and to increase the amount of our outstanding term loans as previously described. All of those borrowings would be senior and secured, and as a result, would be effectively senior to the notes and the guarantees of the notes by the guarantors. If we incur any additional indebtedness that ranks equally with the notes, the holders of that debt will be entitled to share ratably with the holders of the notes in any proceeds distributed in connection with any insolvency, liquidation, reorganization, dissolution or other winding-up of us. This may have the effect of reducing the amount of proceeds paid to you. If new debt is added to our current debt levels, the related risks that we and our subsidiaries now face could intensify.

An increase in interest rates would increase the cost of servicing our debt and could reduce our profitability.

All of the borrowings under the New Credit Facilities bear interest at variable rates. As a result, an increase in interest rates, whether because of an increase in market interest rates or an increase in our own cost of borrowing, would increase the cost of servicing our debt and could materially reduce our profitability. A 0.25% increase in the expected rate of interest under the New Term Loan Credit Facility would increase our annual interest expense by approximately $2.0 million. The impact of such an increase would be more significant than it would be for some other companies because of our substantial debt.

Risks Related to Our Business and Structure

The current challenging economic environment, along with difficult and volatile conditions in the capital and credit markets, could materially adversely affect our financial position, results of operations or cash flows, and we are unsure whether these conditions will improve in the near future.

The U.S. economy and global credit markets remain volatile. Declining consumer confidence and increased unemployment have increased concerns of prolonged economic weakness. While certain healthcare spending is considered non-discretionary and may not be significantly impacted by economic downturns, other types of healthcare spending may be significantly adversely impacted by such conditions. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals. We are unable to determine the specific impact of the current economic conditions on our business at this time, but we believe that further deterioration or a prolonged period of recession will have an adverse impact on our operations. Other risk factors discussed in this prospectus describe some significant risks that may be magnified by the current economic conditions such as the following:

- Our concentration of operations in a small number of regions, and the impact of economic downturns in those communities. To the extent the communities in and around San Antonio, Texas; Phoenix, Arizona; Chicago, Illinois or certain communities in Massachusetts experience a greater degree of economic weakness than average, the adverse impact on our operations could be magnified.

- Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies (including managed Medicare and managed Medicaid payers) reduce our reimbursement. Current economic conditions have accelerated and increased the budget deficits for most states, including those in which we operate. These budgetary pressures may result in healthcare payment reductions under state Medicaid plans or reduced benefits to participants in those plans. Also, governmental, managed Medicare or managed Medicaid payers may defer payments to us to conserve cash. Managed care companies may also seek to reduce payment rates or limit payment rate increases to hospitals in response to reductions in enrolled participants.

- Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts. Higher unemployment, Medicaid benefit reductions and employer efforts to reduce employee healthcare costs may increase our exposure to uncollectible accounts for uninsured patients or those patients with higher co-pay and deductible limits

- Under extreme market conditions, there can be no assurance that funds necessary to run our business will be available to us on favorable terms or at all. Most of our cash and borrowing capacity under our New Credit Facilities will be held with a limited number of financial institutions, which could increase our liquidity risk if one or more of those institutions become financially strained or are no longer able to operate.

We are unable to predict if the condition of the U.S. economy, the local economies in the communities we serve or global credit conditions will improve in the near future or when such improvements may occur.

The current U.S. and state health reform legislative initiatives could adversely affect our operations and business condition.

On March 21, 2010, the House passed the "Patient Protection and Affordable Care Act," the exact version of a healthcare reform bill previously passed by the Senate on December 24, 2009, and the "Health Care and Education Affordability Reconciliation Act of 2010," an accompanying bill that made certain adjustments to the original Senate bill, the most notable of which include more generous subsidies to lower income families to purchase insurance, a delay until 2018 of the tax assessed to generous employer-sponsored health plans and a gradual closing of the Medicare Part D "donut hole." The original Senate bill and the accompanying House bill (as amended by the Senate) were signed by President Obama into law on March 23, 2010 and March 30, 2010, respectively.

The provisions included in the combination of these two bills generally provide increased access to health benefits for uninsured or underinsured populations through the creation of state-based health insurance exchanges and expansion of coverage under Medicaid programs but will exclude a public insurance option. While we would expect these coverage expansions to reduce our historical levels of bad debts, the bills also include other provisions that could negatively impact us. Under the combined bills, federal health program expenditures will be reduced by more than $480.0 billion over 10 years through reductions in the annual market basket updates for Medicare fee-for-service providers, reduced subsidies to Medicare Advantage health plans, reductions in Medicare and Medicaid disproportionate share funding and cuts in payments to hospitals with high readmission rates. The expansion of Medicaid programs could result in additional utilization at our facilities with lower reimbursement than the cost required to provide such services. The combined bills also include pilot programs for hospitals to provide value-based care and to penalize hospitals that perform poorly on certain quality measures and may result in additional medical information technology investments by us.

Most of the provisions of these healthcare bills do not go into effect immediately and may be delayed for several years. During this time, the bills will be subject to further adjustments through future legislation or even constitutional challenges. We will not be able to determine the effects of either or both of these bills on our financial positions, results of operations or cash flows for a significant period of time.

If we are unable to enter into favorable contracts with managed care plans, our operating revenues may be reduced.

Our ability to negotiate favorable contracts with health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans significantly affects the revenues and operating results of our hospitals. Revenues derived from health maintenance organizations, insurers offering preferred provider arrangements and other managed care plans, including managed Medicare and managed Medicaid plans, accounted for approximately 58% and 59% of our net patient revenues for the year ended June 30, 2009 and the nine months ended March 31, 2010, respectively. Managed care organizations offering prepaid and discounted medical services packages represent a significant portion of our admissions, a general trend in the industry which has limited hospital revenue growth nationwide and a trend that may continue. In addition, private payers are increasingly attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations. Additionally, the trend towards consolidation among private managed care payers tends to increase their bargaining prices over fee structures. In most cases, we negotiate our managed care contracts annually as they come up for renewal at various times during the year. Our future success will depend, in part, on our ability to renew existing managed care contracts and enter into new managed care contracts on terms favorable to us. Other healthcare companies, including some with greater financial resources, greater geographic coverage or a wider range of services, may compete with us for these opportunities. If we are unable to contain costs through increased operational efficiencies or to obtain higher reimbursements and payments from managed care payers, our financial position results of operations and cash flows will be materially adversely affected.

Our revenues may decline if federal or state programs reduce our Medicare or Medicaid payments or managed care companies reduce our reimbursements.

Approximately 56% and 57% of our net patient revenues for the year ended June 30, 2009 and the nine months ended March 31, 2010, respectively, came from the Medicare and Medicaid programs, including Medicare and Medicaid managed plans. In recent years, federal and state governments have made significant changes in the Medicare and Medicaid programs. Some of those changes adversely affect the reimbursement we receive for certain services. In addition, due to budget deficits in many states, significant decreases in state funding for Medicaid programs have occurred or are being proposed.

On August 22, 2007, CMS issued a final rule for federal fiscal year 2008 for the hospital inpatient prospective payment system. This rule adopted a two-year implementation of Medicare severity-adjusted diagnosis-related groups ("MS-DRGs"), a severity-adjusted diagnosis-related group ("DRG") system. This change represented a refinement to the DRG system, and its impact on our revenues has not been significant. Realignments in the DRG system could impact the margins we receive for certain services.

DRG rates are updated and MS-DRG weights are recalibrated each federal fiscal year. The index used to update the market basket gives consideration to the inflation experienced by hospitals and entities outside the healthcare industry in purchasing goods and services. The Medicare Inpatient Hospital Prospective System Final Rule for federal fiscal year 2010 provides for a 2.1% market basket update for hospitals that submit certain quality patient care indicators and a 0.1% update for hospitals that do not submit this data. While we will endeavor to comply with all quality data submission requirements, our submissions may not be deemed timely or sufficient to entitle us to the full market basket adjustment for all our hospitals. Medicare payments to hospitals in federal fiscal year 2009 were reduced by 0.9% to eliminate what CMS estimates will be the effect of coding or classification changes as a result of hospitals implementing the MS-DRG system. After earlier proposing an increase in the "documentation and coding adjustment" to 1.9% for federal fiscal year 2010, on July 31, 2009 CMS announced that it had decided not to make any adjustment in federal fiscal year 2010 since it did not know whether federal fiscal year 2009 spending from documentation and coding is more or less than earlier projected. However, the U.S. Congress has given CMS the ability to continue to retrospectively determine if the documentation and coding adjustment levels for federal fiscal years 2008 and 2009 were adequate to account for changes in payments not related to changes in case mix. If the levels are found to have been inadequate, CMS could impose an adjustment to payments for federal fiscal years 2011 and 2012. This evaluation of changes in case-mix based on actual claims data may yield a higher documentation and coding adjustment thereby potentially reducing our revenues and impacting our results of operations in ways that cannot be quantified at this time. Additionally, Medicare payments to hospitals are subject to a number of other adjustments, and the actual impact on payments to specific hospitals may vary. In some cases, commercial third-party payers and other payers such as some state Medicaid programs rely on all or portions of the Medicare DRG system to determine payment rates. The change from traditional Medicare DRGs to MS-DRGs could adversely impact those payment rates if any other payers adopt MS-DRGs.

The federal government and many states have recently adopted or are currently considering reducing the level of Medicaid funding (including upper payment limits) or program eligibility that could adversely affect future levels of Medicaid reimbursement received by our hospitals. Since states must operate with balanced budgets and since the Medicaid program is often a state's largest program, a number of states have adopted, or are considering adopting, legislation designed to reduce their Medicaid expenditures. The Deficit Reduction Act of 2005 ("DRA") includes federal Medicaid cuts of approximately $4.8 billion over five years. Additionally, on May 29, 2007, CMS published a final rule entitled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership" which is estimated to reduce federal Medicaid funding from $12 billion to $20 billion over five years. The U.S. Congress enacted two moratoria in respect of this rule that delayed six of seven proposed Medicaid regulations in this final CMS rule until July 1, 2009. On June 30, 2009, three more of the Medicaid regulations that had been under a congressional moratorium set to expire July 1, 2009 were officially rescinded, all or in part, by CMS, and CMS also delayed until June 30, 2010 the enforcement of the fourth of the six regulations. As a result of these changes in implementing the final rule, the impact on us of the final rule cannot be quantified. States in which we operate have also adopted, or are considering adopting, legislation designed to reduce coverage and program eligibility, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. For example, Arizona has frozen hospital inpatient and outpatient reimbursements at the October 1, 2008 rates and discontinued a state health benefits program for low-income parents. Additional Medicaid spending cuts may be implemented in the future in the states in which we operate, including reductions in supplemental Medicaid reimbursement programs. Our Texas hospitals participate in private supplemental Medicaid reimbursement programs that are structured to expand the community safety net by providing indigent healthcare services and result in additional revenues for participating hospitals. We cannot predict whether the Texas private supplemental Medicaid reimbursement programs will continue or guarantee that revenues recognized from the programs will not decrease. Future legislation or other changes in the administration or interpretation of government health programs could have a material adverse effect on our financial position, results of operations and cash flows.

Our ability to negotiate favorable contracts with managed care plans significantly affects the revenues and operating results of most of our hospitals. Managed care payers increasingly are demanding discounted fee structures, and the trend toward consolidation among managed care plans tends to increase their bargaining power over fee structures. Reductions in price increases or the amounts received from managed care plans could have a material adverse effect on our financial position, results of operations and cash flows.

In recent years, both the Medicare program and several large managed care companies have changed our reimbursement to link some of their payments, especially their annual increases in payments, to performance of quality of care measures. We expect this trend to "pay-for-performance" to increase in the future. If we are unable to meet these performance measures, our financial position, results of operations and cash flows will be materially adversely affected.

We conduct business in a heavily regulated industry, and changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce our revenues and profitability.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensing, the conduct of operations, the ownership of facilities, the addition of facilities and services, financial arrangements with physicians and other referral sources, confidentiality, maintenance and security issues associated with medical records, billing for services and prices for services. If a determination were made that we were in material violation of such laws or regulations, our financial position, results of operations and cash flows could be materially adversely affected.

In many instances, the industry does not have the benefit of significant regulatory or judicial interpretations of these laws and regulations. This is particularly true in the case of the Medicare and Medicaid statute codified under Section 1128B(b) of the Social Security Act and known as the "Anti-Kickback Statute." This law prohibits providers and other person or entities from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent to generate referrals of orders for services or items reimbursable under Medicare, Medicaid and other federal healthcare programs. As authorized by the U.S. Congress, the U.S. Department of Health and Human Services has issued regulations which describe certain conduct and business relationships immune from prosecution under the Anti-Kickback Statute. The fact that a given business arrangement does not fall within one of these "safe harbor" provisions does not render the arrangement illegal, but business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria risk increased scrutiny by enforcement authorities.

The safe harbor requirements are generally detailed, extensive, narrowly drafted and strictly construed. Many of the financial arrangements that our facilities maintain with physicians do not meet all of the requirements for safe harbor protection. The regulatory authorities that enforce the Anti-Kickback Statute may in the future determine that one or more of these arrangements violate the Anti-Kickback Statute or other federal or state laws. In addition, the Senate health reform bill includes provisions that would revise the scienter requirements such that a person need not have actual knowledge of the Anti-Kickback Statute or intent to violate the Anti-Kickback Statute to be found guilty of a violation. A determination that a facility has violated the Anti-Kickback Statute or other federal laws could subject us to liability under the Social Security Act, including criminal and civil penalties, as well as exclusion of the facility from participation in government programs such as Medicare and Medicaid or other federal healthcare programs.

In addition, the portion of the Social Security Act commonly known as the "Stark Law" prohibits physicians from referring Medicare and (to an extent) Medicaid patients to providers of certain "designated health services" if the physician or a member of his or her immediate family has an ownership or investment interest in, or compensation arrangement with, that provider. In addition, the provider in such arrangements is prohibited from billing for all of the designated health services referred by the physician, and, if paid for such services, is required to promptly repay such amounts. Most of the services furnished by our facilities are "designated health services" for Stark Law purposes, including inpatient and outpatient hospital services. There are multiple exceptions to the Stark Law, among others, for physicians maintaining an ownership interest in an entire hospital or having a compensation relationship with the facility as a result of employment agreements, leases, physician recruitment and certain other arrangements. However, each of these exceptions applies only if detailed conditions are met. An arrangement subject to the Stark Law must qualify for an exception in order for the services to be lawfully referred by the physician and billed by the provider.

CMS has issued three phases of final regulations implementing the Stark Law. Phases I and II became effective in January 2002 and July 2004, respectively, and Phase III became effective in December 2007. While these regulations help clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. In addition, in July 2007 CMS proposed far-reaching changes to the regulations implementing the Stark Law that would further restrict the types of arrangements that hospitals and physicians may enter, including additional restrictions on certain leases, percentage compensation arrangements, and agreements under which a hospital purchases services under arrangements. On July 31, 2008, CMS issued a final rule which, in part, finalized and responded to public comments regarding some of its July 2007 proposed major changes to the Stark Law regulations. The most far-reaching of the changes made in this final July 2008 rule effectively prohibit, as of a delayed effective date of October 1, 2009, both "under arrangements" ventures between a hospital and any referring physician or entity owned, in whole or in part, by a referring physician and unit-of-service-based "per click" compensation and percentage-based compensation in office space and equipment leases between a hospital and any referring physician or entity owned, in whole or in part, by a referring physician. We examined all of our "under arrangement" ventures and space and equipment leases with physicians to identify those arrangements which would have failed to conform to these new Stark regulations as of October 1, 2009, and we restructured or terminated all such non-conforming arrangements so identified prior to October 1, 2009. Because the Stark Law and its implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of this law and its regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot assure you that every relationship complies fully with the Stark Law. In addition, in the July 2008 final Stark rule CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. We cannot assure you that the arrangements entered into by our hospitals with physicians will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Additionally, if we violate the Anti-Kickback Statute or Stark Law, or if we improperly bill for our services, we may be found to violate the False Claims Act, either under a suit brought by the government or by a private person under a *qui tam*, or "whistleblower," suit.

If we fail to comply with the Anti-Kickback Statute, the Stark Law, the False Claims Act or other applicable laws and regulations, or if we fail to maintain an effective corporate compliance program, we could be subjected to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities), exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state healthcare programs and, for violations of certain laws and regulations, criminal penalties. See "Item 1. Business — Government Regulation and Other Factors" included in our June 30, 2009 10-K.

All of the states in which we operate have adopted or have considered adopting similar anti-kickback and physician self-referral legislation, some of which extends beyond the scope of the federal law to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals, regardless of the source of payment for the care. Little precedent exists for the interpretation or enforcement of these laws. Both federal and state government agencies have announced heightened and coordinated civil and criminal enforcement efforts.

Government officials responsible for enforcing healthcare laws could assert that one or more of our facilities, or any of the transactions in which we are involved, are in violation of the Anti-Kickback Statute or the Stark Law and related state law exceptions. It is also possible that the courts could ultimately interpret these laws in a manner that is different from our interpretations. Moreover, other healthcare companies, alleged to have violated these laws, have paid significant sums to settle such allegations and entered into "corporate integrity agreements" because of concern that the government might exercise its authority to exclude those providers from governmental payment programs (e.g., Medicare, Medicaid, TRICARE). A determination that one or more of our facilities has violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Federal law permits the Department of Health and Human Services Office of Inspector General ("OIG") to impose civil monetary penalties, assessments or to exclude from participation in federal healthcare programs, individuals and entities who have submitted false, fraudulent or improper claims for payment. Improper claims include those submitted by individuals or entities who have been excluded from participation. These penalties may also be imposed on providers or entities who employ or enter into contracts with excluded individuals to provide services to beneficiaries of federal healthcare programs. Furthermore, if services are provided by an excluded individual or entity, the penalties may apply even if the payment is made directly to a non-excluded entity. Employers of or entities that contract with excluded individuals or entities for the provision of services may be liable for up to $10,000 for each item or service furnished by the excluded individual or entity, an assessment of up to three times the amount claimed and program exclusions. In order for the penalties to apply, the employer or contractor must have known or should have known that the person or entity was excluded from participation. On October 12, 2009, we voluntarily reported to OIG that two past employees of Vanguard Health Systems, Inc. had been excluded from participation in Medicare at certain times during their employment.

Illinois and Massachusetts require governmental determinations of need ("Certificates of Need") prior to the purchase of major medical equipment or the construction, expansion, closure, sale or change of control of healthcare facilities. We believe our facilities have obtained appropriate certificates wherever applicable. However, if a determination were made that we were in material violation of such laws, our operations and financial results could be materially adversely affected. The governmental determinations, embodied in Certificates of Need, can also affect our facilities' ability to add bed capacity or important services. We cannot predict whether we will be able to obtain required Certificates of Need in the future. A failure to obtain any required Certificates of Need may impair our ability to operate the affected facility profitably.

The laws, rules and regulations described above are complex and subject to interpretation. If we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be significantly harmed. For a more detailed discussion of the laws, rules and regulations, see "Item 1. Business—Government Regulation and Other Factors" included in our June 30, 2009 10-K.

Some of our hospitals will be required to submit to CMS information on their relationships with physicians and this submission could subject such hospitals and us to liability.

CMS announced in 2007 that it intends to collect information on ownership, investment and compensation arrangements with physicians from 500 (pre-selected) hospitals by requiring these hospitals to submit to CMS Disclosure of Financial Relationship Reports ("DFRR") from each selected hospital. CMS also indicated that at least 10 of our hospitals will be among these 500 hospitals required to submit a DFRR because these 10 hospitals did not respond to CMS' voluntary survey instrument on this topic purportedly submitted to these hospitals via email by CMS in 2006. CMS intends to use this data to determine whether these hospitals were in compliance with the Stark Law and implementing regulations during the reporting period, and CMS has indicated it may share this information with other government agencies and with congressional committees. Many of these agencies have not previously analyzed this information and have the authority to bring enforcement actions against the hospitals. However, in July 2008 CMS announced that, based on its further review and expected further public comments on this matter, CMS may decide in the future to decrease (but not increase) the number of hospitals to which it will send the DFRR below the 500 hospitals originally designated.

Once a hospital receives this request for a DFRR, the hospital will have 60 days to compile a significant amount of information relating to its financial relationships with physicians. The hospital may be subject to civil monetary penalties of up to $10,000 per day if it is unable to assemble and report this information within the required timeframe or if CMS or any other government agency determines that the submission is inaccurate or incomplete. The hospital may be the subject of investigations or enforcement actions if a government agency determines that any of the information indicates a potential violation of law.

Also, while in 2007 CMS had announced that it was contemplating proposing a regular financial disclosure process that would apply in the future to all Medicare participating hospitals, in July 2008 CMS announced that, based upon public comments previously received, it was not adopting a regular reporting or disclosure process at that time, and, thus, CMS said the DFRR will initially be used as a one-time collection effort. However, CMS also said in July 2008 that, depending on the information received from the initial DFRR process and other factors, it may propose future rulemaking to use the DFRR or some other instrument as a periodic or regular collection instrument. Thus, even if one of our hospitals does not receive the DFRR survey as part of the initial up to 500 selected hospitals, we expect that all of our hospitals will possibly have to report similar information to CMS in the future.

The DFRR and its supporting documentation are currently under review by the Office of Management and Budget and have not yet been released. Depending on the final format of the DFRR, responding hospitals may be subject to substantial penalties as a result of enforcement actions brought by government agencies and whistleblowers acting pursuant to the False Claims Act and similar state laws, based on such allegations like failure to respond within required deadlines, that the response is inaccurate or contains incomplete information or that the response indicates a potential violation of the Stark Law or other requirements.

Any governmental investigation or enforcement action which results from the DFRR process could materially adversely affect our results of operations.

Providers in the healthcare industry have been the subject of federal and state investigations, whistleblower lawsuits and class action litigation, and we may become subject to investigations, whistleblower lawsuits or class action litigation in the future.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of hospital companies, as well as their executives and managers. These investigations relate to a wide variety of topics, including:

- cost reporting and billing practices;
- laboratory and home healthcare services;
- physician ownership of, and joint ventures with, hospitals;
- physician recruitment activities; and
- other financial arrangements with referral sources.

In addition, the federal False Claims Act permits private parties to bring *qui tam*, or whistleblower, lawsuits against companies. Whistleblower provisions allow private individuals to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. Because *qui tam* lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. Defendants determined to be liable under the False Claims Act may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $5,500 and $11,000 for each separate false claim. Typically, each fraudulent bill submitted by a provider is considered a separate false claim, and thus the penalties under the False Claims Act may be substantial. Liability arises when an entity knowingly submits a false claim for reimbursement to the federal government. The Fraud Enforcement and Recovery Act, which became law on May 20, 2009, changes the scienter requirements for liability under the False Claims Act. An entity may now violate the False Claims Act if it "knowingly and improperly avoids or decreases an obligation" to pay money to the United States. This includes obligations based on an "established duty . . . arising from . . . the retention of any overpayment." Thus, if a provider is aware that it has retained an overpayment that it has an obligation to refund, this may form the basis of a False Claims Act violation even if the provider did not know the claim was "false" when it was submitted. In some cases, whistleblowers or the federal government have taken the position that providers who allegedly have violated other statutes and have submitted claims to a governmental payer during the time period they allegedly violated these other statutes, have thereby submitted false claims under the False Claims Act. Such other statutes include the Anti-Kickback

Statute and the Stark Law. Courts have held that violations of these statutes can properly form the basis of a False Claims Act case. Some states have adopted similar whistleblower and false claims provisions.

The Office of the Inspector General of the U.S. Department of Health and Human Services and the U.S. Department of Justice have, from time to time, established national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. Initiatives include a focus on hospital billing for outpatient charges associated with inpatient services, as well as hospital laboratory, home health and durable medical equipment billing practices. As a result of these regulations and initiatives, some of our activities could become the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, we provide some durable medical equipment and home healthcare services, and we have joint venture arrangements involving physician investors. We also have a variety of other financial arrangements with physicians and other potential referral sources including recruitment arrangements and leases. In addition, our executives and managers, many of whom have worked at other healthcare companies that are or may become the subject of federal and state investigations and private litigation, could be included in governmental investigations or named as defendants in private litigation. We are aware that several of our hospitals or their related healthcare operations were and may still be under investigation in connection with activities conducted prior to our acquisition of them. Under the terms of our various acquisition agreements, the prior owners of our hospitals are responsible for any liabilities arising from pre-closing violations. The prior owners' resolution of these matters or failure to resolve these matters, in the event that any resolution was deemed necessary, may have a material adverse effect on our business, financial condition or results of operations. Any investigations of us, our executives, managers, facilities or operations could result in significant liabilities or penalties to us, as well as adverse publicity.

We maintain a voluntary compliance program to address health regulatory and other compliance requirements. This program includes initial and periodic ethics and compliance training, a toll-free hotline for employees to report, without fear of retaliation, any suspected legal or ethical violations, annual "fraud and abuse" audits to look at our financial relationships with physicians and other referral sources and annual "coding audits" to make sure our hospitals bill the proper service codes in respect of obtaining payment from the Medicare and Medicaid programs.

As an element of our corporate compliance program and our internal compliance audits, from time to time we make voluntary disclosures and repayments to the Medicare and Medicaid programs and/or to the federal and/or state regulators for these programs in the ordinary course of business. At the current time, we know of no active investigations by any of these programs or regulators in respect of our disclosures or repayments. All of these voluntary actions on our part could lead to an investigation by the regulators to determine whether any of our facilities have violated the Stark Law, the Anti-Kickback Statute, the False Claims Act or similar state law. Either an investigation or initiation of administrative or judicial actions could result in a public announcement of possible violations of the Stark Law, the Anti-Kickback Statute or the False Claims Act or similar state law. Such determination or announcements could have a material adverse effect on our business, financial condition, results of operations or prospects, and our business reputation could suffer significantly.

Additionally, several hospital companies have in recent years been named defendants in class action litigation alleging, among other things, that their charge structures are fraudulent and, under state law, unfair or deceptive practices, insofar as those hospitals charge insurers lower rates than those charged to uninsured patients. We cannot assure you that we will not be named as a defendant in litigation of this type. Furthermore, the outcome of these suits may affect the industry standard for charity care policies and any response we take may have a material adverse effect on our financial results.

In June 2006, we and two other hospital systems operating in San Antonio, Texas had a putative class action lawsuit brought against all of us alleging that we and the other defendants had conspired with one another and with other unidentified San Antonio area hospitals to depress the compensation levels of registered nurses employed at the competing hospitals within the San Antonio area by engaging in certain activities that violated the federal antitrust laws. See "Other Information — Legal Proceedings" included in our December 31, 2009 Current Report on Form 10-Q for further discussion on this litigation, since there have been no significant developments during the current quarter. On the same day that this litigation was brought against us and two other hospital systems in San Antonio, substantially similar class action litigation was brought against multiple hospitals in three other cities.

Competition from other hospitals or healthcare providers (especially specialty hospitals) may reduce our patient volumes and profitability.

The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Generally, other hospitals in the local communities served by most of our hospitals provide services similar to those offered by our hospitals. In addition, we believe the number of freestanding specialty hospitals and surgery and diagnostic centers in the geographic areas in which we operate has increased significantly in recent years. As a result, most of our hospitals operate in an increasingly competitive environment. Some of the hospitals that compete with our hospitals are owned by governmental agencies or not-for-profit corporations supported by endowments and charitable contributions and can finance capital expenditures and operations on a tax-exempt basis. Increasingly, we are facing competition from physician-owned specialty hospitals and freestanding surgery centers that compete for market share in high margin services and for quality physicians and personnel. If ambulatory surgery centers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our ambulatory surgery centers. Further, if our competitors are better able to attract patients, recruit physicians, expand services or obtain favorable managed care contracts at their facilities than our hospitals and ambulatory surgery centers, we may experience an overall decline in patient volume. See "Business — Competition" included in our June 30, 2009 10-K.

In 2005, CMS began making public performance data related to 10 quality measures that hospitals submit in connection with their Medicare reimbursement. In February 2006, federal legislation was enacted to expand and provide for the future expansion of the number of quality measures that must be reported. During federal fiscal year 2008, CMS required hospitals to report 30 measures of inpatient quality of care to avoid a 2% point reduction in their market basket update. During federal fiscal year 2009, CMS required hospitals to report 43 inpatient quality measures to avoid a 2% point reduction in their market basket update. For federal fiscal year 2010, CMS will require hospitals to report 47 inpatient quality measures to avoid a 2% reduction in their market basket update. If any of our hospitals achieve poor results (or results that are lower than our competitors) on these quality measures, patient volumes could decline. Also, the additional quality measures and future trends toward clinical transparency may have an unanticipated impact on our competitive position and patient volumes.

Our Phoenix Health Plan unit ("PHP") also faces competition within the Arizona markets that it serves. As in the case of our hospitals, some of our health plan competitors in these markets are owned by governmental agencies or not-for-profit corporations that have greater financial resources than we do. The revenues we derive from PHP could significantly decrease if new plans operating in the Arizona Health Care Cost Containment System ("AHCCCS"), which is Arizona's state Medicaid program, enter these markets or other existing AHCCCS plans increase their number of enrollees. Moreover, a failure to attract future enrollees may negatively impact our ability to maintain our profitability in these markets.

We may be subject to liabilities from claims brought against our facilities.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been instituted or asserted against us, including those outside of the ordinary course of business such as class actions and those in the ordinary course of business such as malpractice lawsuits. Some of these actions may involve large claims as well as significant defense costs. See "Other Information - Legal Proceedings" included in our December 31, 2009 Current Report on Form 10-Q for additional information, since there have been no significant developments during the current quarter.

We maintain professional and general liability insurance with unrelated commercial insurance carriers to provide for losses in excess of our self-insured retention (directly, or indirectly, through an insurance subsidiary) of $10.0 million. As a result, a few successful claims against us that are within our self-insured retention amounts could have an adverse effect on our results of operations, cash flows, financial condition or liquidity. In addition, one or more claims could exceed the scope of the third-party coverage in effect or the coverage of particular claims or damages could be denied.

Additionally, we experienced unfavorable claims development results during our first nine months of fiscal 2010, which are reflected in our professional and general liability costs. The relatively high cost of professional liability insurance and, in some cases, the lack of availability of such insurance coverage, for physicians with privileges at our hospitals increases our risk of vicarious liability in cases where both our hospital and the uninsured or underinsured physician are named as co-defendants. As a result, we are subject to greater self-insured risk and may be required to fund claims out of our operating cash flows to a greater extent than during fiscal year 2009. We cannot assure you that we will be able to continue to obtain insurance coverage in the future or that such insurance coverage, if it is available, will be available on acceptable terms.

While we cannot predict the likelihood of future claims or inquiries, we expect that new matters may be initiated against us from time to time. Moreover, the results of current claims, lawsuits and investigations cannot be predicted, and it is possible that the ultimate resolution of these matters, individually or in the aggregate, may have a material adverse effect on our business (both in the near and long term), financial position, results of operations or cash flows.

Our hospitals face a growth in uncompensated care as the result of the inability of uninsured patients to pay for healthcare services and difficulties in collecting patient portions of insured accounts.

Like others in the hospital industry, we have experienced an increase in uncompensated care. Our combined provision for doubtful accounts, uninsured discounts and charity care deductions as a percentage of patient service revenues (prior to these adjustments) was 12.0% during both fiscal 2008 and 2009. This ratio increased to 15.7% for the nine months ended March 31, 2010. Approximately 350 basis points of this increase related to the uninsured discount and Medicaid pending policy changes implemented in our Illinois hospitals effective April 1, 2009 and in our Phoenix and San Antonio hospitals effective July 1, 2009. Our self-pay discharges as a percentage of total discharges have fluctuated only slightly between 3.3% and 3.7% during the past three fiscal years and during the nine months ended March 31, 2010 (as adjusted for our Medicaid pending policy changes in Illinois on April 1, 2009 and in Phoenix and San Antonio on July 1, 2009). Our hospitals remain at risk for increases in uncompensated care as a result of price increases, the continuing trend of increases in coinsurance and deductible portions of managed care accounts and increases in uninsured patients as a result of potential state Medicaid funding cuts or general economic weakness. Although we continue to seek ways of improving point of service collection efforts and implementing appropriate payment plans with our patients, if we continue to experience growth in self-pay revenues, our results of operations could be materially adversely affected. Further, our ability to improve collections for self-pay patients may be limited by regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

Our performance depends on our ability to recruit and retain quality physicians.

Physicians generally direct the majority of hospital admissions. Thus, the success of our hospitals depends in part on the following factors:

- the number and quality of the physicians on the medical staffs of our hospitals;
- the admitting practices of those physicians; and
- the maintenance of good relations with those physicians.

Most physicians at our hospitals also have admitting privileges at other hospitals. Our efforts to attract and retain physicians are affected by our managed care contracting relationships, national shortages in some specialties, such as anesthesiology and radiology, the adequacy of our support personnel, the condition of our facilities and medical equipment, the availability of suitable medical office space and federal and state laws and regulations prohibiting financial relationships that may have the effect of inducing patient referrals. If facilities are not staffed with adequate support personnel or technologically advanced equipment that meets the needs of patients, physicians may be discouraged from referring patients to our facilities, which could adversely affect our profitability.

In an effort to meet community needs in the markets in which we operate, we have implemented a strategy to employ physicians both in primary care and in certain specialties. As of March 31, 2010, we employed more than 300 practicing physicians, excluding residents. The deployment of a physician employment strategy includes increased salary and benefits costs, physician integration risks and difficulties associated with physician practice management. While we believe this strategy is consistent with industry trends, we cannot be assured of the long-term success of such a strategy. In addition, if we raise wages in response to our competitors' wage increases and are unable to pass such increases on to our clients, our margins could decline, which could adversely affect our business, financial condition and results of operations.

We may be unable to achieve our acquisition and growth strategies and we may have difficulty acquiring not-for-profit hospitals due to regulatory scrutiny.

An important element of our business strategy is expansion by acquiring hospitals in our existing and in new urban and suburban markets and by entering into partnerships or affiliations with other healthcare service providers. The competition to acquire hospitals is significant, including competition from healthcare companies with greater financial resources than ours. We have not acquired a hospital since December 2004. While we currently have non-binding letters of intent in place for

multiple acquisitions, there is no guarantee we will be able to complete these or any other hospital acquisitions, which would seriously impact our ability to grow our business.

Even if we are able to acquire more hospitals, such acquisitions may be on less than favorable terms. We may have difficulty obtaining financing, if necessary, for such acquisitions on satisfactory terms. Potential acquisitions may include significant future capital or other funding commitments that we may not be able to finance through operating cash flows or additional debt or equity proceeds. We sometimes agree not to sell an acquired hospital for some period of time (currently no longer than 10 years) after purchasing it and/or grant the seller a right of first refusal to purchase the hospital if we agree to sell it to a third party. In addition, we may not be able to effectively integrate any acquired facilities with our operations. Even if we continue to acquire additional facilities and/or enter into partnerships or affiliations with other healthcare service providers, federal and state regulatory agencies may constrain our ability to grow.

Additionally, many states, including some where we have hospitals and others where we may in the future attempt to acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, the attorneys general have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. These legislative and administrative efforts focus primarily on the appropriate valuation of the assets divested and the use of the sale proceeds by the not-for-profit seller. These review and approval processes can add time to the consummation of an acquisition of a not-for-profit hospital, and future actions on the state level could seriously delay or even prevent future acquisitions of not-for-profit hospitals. Furthermore, as a condition to approving an acquisition, the attorney general of the state in which the hospital is located may require us to maintain specific services, such as emergency departments, or to continue to provide specific levels of charity care, which may affect our decision to acquire or the terms upon which we acquire one of these hospitals.

Future acquisitions or joint ventures may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.

As part of our growth strategy, we may pursue acquisitions or joint ventures of hospitals or other related healthcare facilities and services. These acquisitions or joint ventures may involve significant cash expenditures, debt incurrence, additional operating losses and expenses that could have a material adverse effect on our financial condition and results of operations. Acquisitions or joint ventures involve numerous risks, including:

- difficulty and expense of integrating acquired personnel into our business;
- diversion of management's time from existing operations;
- potential loss of key employees or customers of acquired companies; and
- assumption of the liabilities and exposure to unforeseen liabilities of acquired companies, including liabilities for failure to comply with healthcare regulations.

We cannot assure you that we will succeed in obtaining financing for acquisitions or joint ventures at a reasonable cost, or that such financing will not contain restrictive covenants that limit our operating flexibility. We also may be unable to operate acquired hospitals profitably or succeed in achieving improvements in their financial performance.

The cost of our malpractice insurance and the malpractice insurance of physicians who practice at our facilities remains volatile. Successful malpractice or tort claims asserted against us, our physicians or our employees could materially adversely affect our financial condition and profitability.

Physicians, hospitals and other healthcare providers are subject to legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. Hospitals and physicians have typically maintained a special type of insurance (commonly called malpractice or professional liability insurance) to protect against the costs of these types of legal actions. We created a captive insurance subsidiary on June 1, 2002, to assume a substantial portion of the professional and general liability risks of our facilities. For claims incurred during the period June 1, 2002 to May 31, 2006 and those subsequent to June 30, 2009, we maintained all of our professional and general liability insurance through this captive insurance subsidiary in respect of losses up to $10.0 million per occurrence. For claims incurred from June 1, 2006 to June 30, 2009, we self-insured the first $9.0 million per occurrence, and

our captive subsidiary insured the next $1.0 million per occurrence. We have also purchased an umbrella excess policy for professional and general liability insurance for the period July 1, 2009 to June 30, 2010 with unrelated commercial carriers. This policy covers losses in excess of $10.0 million per occurrence up to $75.0 million, but is limited to total annual payments of $65.0 million in the aggregate. While our premium prices have declined during the past few years, the total cost of professional and general liability insurance remains sensitive to the volume and severity of cases reported. There is no guarantee that excess insurance coverage will continue to be available in the future at a cost allowing us to maintain adequate levels of such insurance. Moreover, due to the increased retention limits insured by us and our captive subsidiary, if actual payments of claims materially exceed our projected estimates of malpractice claims, our financial condition, results of operations and cash flows could be materially adversely affected.

Physicians' professional liability insurance costs in certain markets have dramatically increased to the point where some physicians are either choosing to retire early or leave those markets. If physician professional liability insurance costs continue to escalate in markets in which we operate, some physicians may choose not to practice at our facilities, which could reduce our patient volumes and revenues. Our hospitals may also incur a greater percentage of the amounts paid to claimants if physicians are unable to obtain adequate malpractice coverage since we are often sued in the same malpractice suits brought against physicians on our medical staffs who are not employed by us.

We expect to continue to employ additional physicians during the near future. A significant increase in employed physicians could significantly increase our professional and general liability risks and related costs in future periods since for employed physicians there is no insurance coverage from unaffiliated insurance companies.

Our facilities are concentrated in a small number of regions. If any one of the regions in which we operate experiences a regulatory change, economic downturn or other material change, our overall business results may suffer.

Among our operations as of March 31, 2010, five hospitals and various related healthcare businesses were located in San Antonio, Texas; five hospitals and related healthcare businesses were located in metropolitan Phoenix, Arizona; two hospitals and related healthcare businesses were located in metropolitan Chicago, Illinois; and three hospitals and related healthcare businesses were located in Massachusetts.

For the year ended June 30, 2009 and the nine months ended March 31, 2010, our total revenues were generated as follows:

	Year Ended June 30, 2009	Nine Months Ended March 31, 2010
San Antonio	29.6%	26.2%
Phoenix Health Plan and Abrazo Advantage Health Plan	19.3	23.1
Massachusetts	18.3	18.3
Metropolitan Phoenix, excluding Phoenix Health Plan and Abrazo Advantage Health Plan	17.9	18.1
Metropolitan Chicago (1)	14.6	14.1
Other	0.3	0.2
	100.0%	100.0%

(1) Includes MacNeal Health Providers

Any material change in the current demographic, economic, competitive or regulatory conditions in any of these regions could adversely affect our overall business results because of the significance of our operations in each of these regions to our overall operating performance. Moreover, due to the concentration of our revenues in only four regions, our business is less diversified and, accordingly, is subject to greater regional risk than that of some of our larger competitors.

If we are unable to control our healthcare costs at Phoenix Health Plan and Abrazo Advantage Health Plan, if the health plans should lose their governmental contracts or if budgetary cuts reduce the scope of Medicaid or dual-eligibility coverage, our profitability may be adversely affected.

For the year ended June 30, 2009 and the nine months ended March 31, 2010, PHP generated approximately 18.1% and 22.0% of our total revenues, respectively. PHP derives substantially all of its revenues through a contract with AHCCCS. AHCCCS pays capitated rates to PHP, and PHP subcontracts with physicians, hospitals and other healthcare providers to provide services to its enrollees. If we fail to effectively manage our healthcare costs, these costs may exceed the payments we receive. Many factors can cause actual healthcare costs to exceed the capitated rates paid by AHCCCS, including:

- our ability to contract with cost-effective healthcare providers;
- the increased cost of individual healthcare services;
- the type and number of individual healthcare services delivered; and
- the occurrence of catastrophes, epidemics or other unforeseen occurrences.

Our current contract with AHCCCS began October 1, 2008 and expires September 30, 2011. This contract is terminable without cause on 90 days' written notice from AHCCCS or for cause upon written notice from AHCCCS if we fail to comply with any term or condition of the contract or fail to take corrective action as required to comply with the terms of the contract. AHCCCS may also terminate the contract with PHP in the event of unavailability of state or federal funding. If our AHCCCS contract is terminated, our profitability would be adversely affected by the loss of these revenues and cash flows. Also, should the scope of the Medicaid program be reduced as a result of state budgetary cuts or other political factors, our results of operations could be adversely affected.

For the year ended June 30, 2009 and the nine months ended March 31, 2010, AAHP generated 1.2% and 1.1% of our total revenues, respectively. AAHP began providing healthcare coverage to Medicare and Medicaid dual-eligible enrollees on January 1, 2006. Most of AAHP's members were formerly enrolled in PHP. AAHP's contract with CMS went into effect on January 1, 2006, for a term of one year, with a provision for successive one year renewals, and has currently been renewed through December 31, 2010. If we fail to effectively manage AAHP's healthcare costs, these costs may exceed the payments we receive.

We are dependent on our senior management team and local management personnel, and the loss of the services of one or more of our senior management team or key local management personnel could have a material adverse effect on our business.

The success of our business is largely dependent upon the services and management experience of our senior management team, which includes Charles N. Martin, Jr., our Chairman and Chief Executive Officer; Kent H. Wallace, our President and Chief Operating Officer; Keith B. Pitts, our Vice Chairman, Phillip W. Roe, our Executive Vice President, Chief Financial Officer and Treasurer; and Joseph D. Moore, Executive Vice President. In addition, we depend on our ability to attract and retain local managers at our hospitals and related facilities, on the ability of our senior officers and key employees to manage growth successfully and on our ability to attract and retain skilled employees. We do not maintain key man life insurance policies on any of our officers. If we were to lose any of our senior management team or members of our local management teams, or if we are unable to attract other necessary personnel in the future, it could have a material adverse effect on our business, financial condition and results of operations. If we were to lose the services of one or more members of our senior management team or a significant portion of our hospital management staff at one or more of our hospitals, we would likely experience a significant disruption in our operations and failure of the affected hospitals to adhere to their respective business plans.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare and commercial third-party payers designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by managed care plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payer-required preadmission authorization and utilization review and by payer pressures to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

Our facilities are subject to extensive federal and state laws and regulations relating to the privacy of individually identifiable information.

The Health Insurance Portability and Accountability Act of 1996 required the U.S. Department of Health and Human Services to adopt standards to protect the privacy and security of individually identifiable health-related information. The department released final regulations containing privacy standards in December 2000 and published revisions to the final regulations in August 2002. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") — one part of the American Recovery and Reinvestment Act of 2009 ("ARRA") — broadened the scope of the HIPAA privacy and security regulations. On August 24, 2009, HHS issued an Interim Final Rule addressing security breach notification requirements and, on October 30, 2009, issued an Interim Final Rule implementing amendments to the enforcement regulations under HIPAA. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. The regulations also provide patients with significant rights related to understanding and controlling how their health information is used or disclosed. The security regulations require healthcare providers to implement administrative, physical and technical practices to protect the security of individually identifiable health information that is maintained or transmitted electronically.

Violations of the Health Insurance Portability and Accountability Act of 1996 could result in civil or criminal penalties. An investigation or initiation of civil or criminal actions could have a material adverse effect on our business, financial condition, results of operations or prospects and our business reputation could suffer significantly. In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. We have developed a comprehensive set of policies and procedures in our efforts to comply with the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. Our compliance officers are responsible for implementing and monitoring compliance with our privacy and security policies and procedures at our facilities. We believe that the cost of our compliance with the Health Insurance Portability and Accountability Act of 1996 and other federal and state privacy laws will not have a material adverse effect on our business, financial condition, results of operations or cash flows.

As a result of increased post-payment reviews of claims we submit to Medicare for our services, we may incur additional costs and may be required to repay amounts already paid to us.

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare for payment for our services. These post-payment reviews are increasing as a result of new government cost-containment initiatives, including enhanced medical necessity reviews for Medicare patients admitted to long-term care hospitals, and audits of Medicare claims under the Recovery Audit Contractor program ("RAC"). The RAC program began as a demonstration project in 2005 in three states (New York, California and Florida) and was expanded into the three additional states of Arizona, Massachusetts and South Carolina in July 2007. The program was made permanent by the Tax Relief and Health Care Act of 2006 enacted in December 2006. CMS ended the demonstration project in March 2008 and commenced the permanent RAC program in all states beginning in 2009 with plans to have RACs in full operation in all 50 states by 2010.

RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments, such as incorrectly coded services, incorrect payment amounts, non-covered services and duplicate payments. The RAC review is either "automated", for which a decision can be made without reviewing a medical record, or "complex", for which the RAC must contact the provider in order to procure and review the medical record to make a decision about the payment. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Claims identified as overpayments will be subject to the Medicare appeals process.

These additional post-payment reviews may require us to incur additional costs to respond to requests for records and to pursue the reversal of payment denials, and ultimately may require us to refund amounts paid to us by Medicare that are determined to have been overpaid.

If we fail to continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.

Technological advances with respect to computed axial tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) equipment, as well as other equipment used in our facilities, are continually evolving. In an effort to compete with other healthcare providers, we must constantly evaluate our equipment needs and upgrade equipment as a result of technological improvements. Such equipment costs typically range from $1.0 million to $3.0 million, exclusive of construction or build-out costs. If we fail to remain current with the technological advancements of the medical community, our volumes and revenue may be negatively impacted.

Our hospitals face competition for staffing especially as a result of the national shortage of nurses and the increased imposition on us of nurse-staffing ratios, which has in the past and may in the future increase our labor costs and materially reduce our profitability.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our hospitals, including most significantly nurses and other non-physician healthcare professionals. In the healthcare industry generally, including in our markets, the national shortage of nurses and other medical support personnel has become a significant operating issue. This shortage has caused us in the past and may require us in the future to increase wages and benefits to recruit and retain nurses and other medical support personnel or to hire more expensive temporary personnel. We have voluntarily raised on several occasions in the past, and expect to raise in the future, wages for our nurses and other medical support personnel.

In addition, union-mandated or state-mandated nurse-staffing ratios significantly affect not only labor costs, but may also cause us to limit patient admissions with a corresponding adverse effect on revenues if we are unable to hire the appropriate number of nurses to meet the required ratios. While we do not currently operate in any states with mandated nurse-staffing ratios, the states in which we operate could adopt mandatory nurse-staffing ratios at any time. In those instances where our nurses are unionized, it is our experience that new union contracts often impose significant new additional staffing ratios by contract on our hospitals. This was the case with the increased staffing ratios imposed on us in our union contract with our nurses at Saint Vincent Hospital in Worcester, Massachusetts negotiated in 2007.

The U.S. Congress is currently considering a bill called the Employee Free Choice Act of 2009 ("EFCA"), which organized labor, a major supporter of the Obama administration, has called its number one legislative objective. EFCA would amend the National Labor Relations Act to establish a procedure whereby the National Labor Relations Board ("NLRB") would certify a union as the bargaining representative of employees, without a NLRB-supervised secret ballot election, if a majority of unit employees signs valid union authorization cards (the "card-check provision"). Additionally, under EFCA, parties that are unable to reach a first contract within 90 days of collective bargaining could refer the dispute to mediation by the Federal Mediation and Conciliation Service (the "Service"). If the Service is unable to bring the parties to agreement within 30 days, the dispute then would be referred to binding arbitration. Also, the bill would provide for increased penalties for labor law violations by employers. In July 2009, due to intense opposition from the business community, alternative draft legislation became public, dropping the card-check provision, but putting in its place new provisions making it easier for employees to organize including provisions to require shorter unionization campaigns, faster elections and limitations on employer-sponsored anti-unionization meetings, which employees are required to attend. This legislation, if passed, would make it easier for our nurses or other groups of hospital employees to unionize, which could materially increase our labor costs.

If our labor costs continue to increase, we may not be able to raise our payer reimbursement levels to offset these increased costs, including the significantly increased costs that we will incur for wage increases and nurse-staffing ratios under our new union contract with our nurses at Saint Vincent Hospital. Because substantially all of our net patient revenues consist of payments based on fixed or negotiated rates, our ability to pass along increased labor costs is materially constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs, could have a material adverse effect on our profitability.

Compliance with Section 404 of the Sarbanes-Oxley Act may negatively impact our results of operations and failure to comply may subject us to regulatory scrutiny and a loss of investors' confidence in our internal control over financial reporting.

Section 404 of the Sarbanes-Oxley Act of 2002 ("Section 404") requires us to perform an evaluation of our internal control over financial reporting and file management's attestation with our annual report. Section 404 also requires our independent registered public accounting firm to opine on our internal control over financial reporting beginning with our fiscal year ending June 30, 2010. We have evaluated, tested and implemented internal controls over financial reporting to enable management to report on such internal controls under Section 404. However, we cannot assure you that the conclusions we will reach in our June 30, 2010 management report will be the same as those reached by our independent registered public accounting firm in their report. Failure on our part to comply with Section 404 may subject us to regulatory scrutiny and a loss of public confidence in the reliability of our financial statements. In addition, we may be required to incur costs in improving our internal control over financial reporting and hiring additional personnel. Any such actions could negatively affect our results of operations.

A failure of our information systems would adversely affect our ability to properly manage our operations.

We rely on our advanced information systems and our ability to successfully use these systems in our operations. These systems are essential to the following areas of our business operations, among others:

- patient accounting, including billing and collection of patient service revenues;
- financial, accounting, reporting and payroll;
- coding and compliance;
- laboratory, radiology and pharmacy systems;
- remote physician access to patient data;
- negotiating, pricing and administering managed care contracts; and
- monitoring quality of care.

If we are unable to use these systems effectively, we may experience delays in collection of patient service revenues and may not be able to properly manage our operations or oversee compliance with laws or regulations.

Difficulties with current construction projects or new construction projects such as additional hospitals or major expansion projects may involve significant capital expenditures that could have an adverse impact on our liquidity.

During the quarter ended March 31, 2010, we entered into a contract to construct a replacement facility for one of our San Antonio hospitals, and we may decide to construct an additional hospital or hospitals in the future or construct additional major expansion projects to existing hospitals in order to achieve our growth objectives. Our ability to complete construction of new hospitals or new expansion projects on budget and on schedule would depend on a number of factors, including, but not limited to:

- our ability to control construction costs;
- the failure of general contractors or subcontractors to perform under their contracts;
- adverse weather conditions;
- shortages of labor or materials;
- our ability to obtain necessary licensing and other required governmental authorizations; and
- other unforeseen problems and delays.

As a result of these and other factors, we cannot assure you that we will not experience increased construction costs on our construction projects or that we will be able to construct our current or any future construction projects as originally planned. In addition, our current and any future major construction projects would involve a significant commitment of capital with no revenues associated with the projects during construction, which also could have a future adverse impact on our liquidity.

If the costs for construction materials and labor continue to rise, such increased costs could have an adverse impact on the return on investment relating to our expansion projects.

The cost of construction materials and labor has significantly increased over the past years as a result of global and domestic events. We have experienced significant increases in the cost of steel due to the demand in China for such materials and an increase in the cost of lumber due to multiple factors. Increases in oil and gas prices have increased costs for oil-based products and for transporting materials to job sites. As we continue to invest in new facilities, modern technologies, emergency rooms and operating room expansions, we expend large sums of cash generated from operating activities. We evaluate the financial viability of such projects based on whether the projected cash flow return on investment exceeds our cost of capital. Such returns may not be achieved if the cost of construction continues to rise significantly or anticipated volumes do not materialize.

State efforts to regulate the construction or expansion of hospitals could impair our ability to operate and expand our operations.

Some states require healthcare providers to obtain prior approval, known as certificates of need, for:

- the purchase, construction or expansion of healthcare facilities;
- capital expenditures exceeding a prescribed amount; or
- changes in services or bed capacity.

In giving approval, these states consider the need for additional or expanded healthcare facilities or services. Illinois and Massachusetts are the only states in which we currently own hospitals that have certificate-of-need laws. The failure to obtain any required certificate of need could impair our ability to operate or expand operations in these states.

If the fair value of our reporting units declines, a material non-cash charge to earnings from impairment of our goodwill could result.

Blackstone acquired our predecessor company during fiscal 2005. We recorded a significant portion of the purchase price as goodwill. At March 31, 2010, we had approximately $649.1 million of goodwill recorded on our financial statements. There is no guarantee that we will be able to recover the carrying value of this goodwill through our future cash flows. On an ongoing basis, we evaluate, based on the fair value of our reporting units, whether the carrying value of our goodwill is impaired. During fiscal 2007, we recorded a $123.8 million ($110.5 million, net of tax benefit) impairment charge to goodwill to reduce the carrying values of our Chicago hospitals to their fair values. Our two Chicago hospitals have experienced deteriorating economic factors that have negatively impacted their results of operations and cash flows. While various initiatives mitigated the impact of these economic factors in fiscal years 2008 and 2009, the operating results of the Chicago hospitals did not improve to the level anticipated during the first six months of fiscal year 2010. After having the opportunity to evaluate the operating results of the Chicago hospitals for the first six months of fiscal year 2010 and to reassess the market trends and economic factors, we concluded that it was unlikely that previously projected cash flows for these hospitals would be achieved. We performed an interim goodwill impairment test during the quarter ended December 31, 2009 and, based upon revised projected cash flows, market participant data and appraisal information, we determined that the $43.1 million remaining goodwill related to this reporting unit was impaired. We recorded the $43.1 million ($31.8 million, net of taxes) non-cash impairment loss in our condensed consolidated statement of operations for the quarter ended December 31, 2009.

Our hospitals are subject to potential responsibilities and costs under environmental laws that could lead to material expenditures or liability.

We are subject to various federal, state and local environmental laws and regulations, including those relating to the protection of human health and the environment. We could incur substantial costs to maintain compliance with these laws and regulations. To our knowledge, we have not been and are not currently the subject of any investigations relating to noncompliance with environmental laws and regulations. We could become the subject of future investigations, which could lead to fines or criminal penalties if we are found to be in violation of these laws and regulations. The principal environmental requirements and concerns applicable to our operations relate to proper management of hazardous materials, hazardous waste and medical waste, above-ground and underground storage tanks, operation of boilers, chillers and other equipment, and management of building conditions, such as the presence of mold, lead-based paint or asbestos. Our hospitals

engage independent contractors for the transportation and disposal of hazardous waste, and we require that our hospitals be named as additional insureds on the liability insurance policies maintained by these contractors.

We also may be subject to requirements related to the remediation of substances that have been released into the environment at properties owned or operated by us or our predecessors or at properties where substances were sent for off-site treatment or disposal. These remediation requirements may be imposed without regard to fault, and liability for environmental remediation can be substantial.

Item 6. Exhibits.

The exhibits filed as part of this report are listed in the Index to Exhibits which is located at the end of this report.

SIGNATURE

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

DATE: May 11, 2010

VANGUARD HEALTH SYSTEMS, INC.

BY: /s/ Gary D. Willis
Gary D. Willis
Senior Vice President, Controller and Chief Accounting Officer
(Authorized Officer and Chief Accounting Officer)

INDEX TO EXHIBITS

Exhibit No.	Description
4	First Supplemental Indenture, dated as of February 25, 2010, among Vanguard Health Holding Company II, LLC, Vanguard Holding Company II, Inc., the Guarantors party thereto and the Trustee. (Incorporated by reference from Exhibit 4.4 to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 (Registration No. 333-165157)).
10.1	Security Agreement, dated as of January 29, 2010, made by each assignor party thereto in favor of Bank of America, N.A., as collateral agent. (Incorporated by reference from Exhibit 10.2 to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 (Registration No. 333-165157)).
10.2	Vanguard Guaranty, dated as of January 29, 2010, made by and among Vanguard Health Systems, Inc. in favor of Bank of America, N.A., as administrative agent. (Incorporated by reference from Exhibit 10.3 to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 (Registration No. 333-165157)).
10.3	Subsidiaries Guaranty, dated as of January 29, 2010, made by and among each of the guarantors party thereto in favor of Bank of America, N.A., as administrative agent. (Incorporated by reference from Exhibit 10.4 to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 (Registration No. 333-165157)).
10.4	Pledge Agreement, dated as of January 29, 2010, among each of the pledgors party thereto and Bank of America, N.A., as collateral agent. (Incorporated by reference from Exhibit 10.5 to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 (Registration No. 333-165157)).
10.5	Amendment No. 2, dated as of January 13, 2010, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings, LLC. (Incorporated by reference from Exhibit 10.71 to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 (Registration No. 333-165157)).
10.6	Amendment No. 3, dated as of January 28, 2010, to Amended and Restated Limited Liability Company Operating Agreement of VHS Holdings, LLC. (Incorporated by reference from Exhibit 10.72 to Vanguard Health Systems, Inc.'s Registration Statement on Form S-4 (Registration No. 333-165157)).
31.1	Certification of CEO pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of CFO pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of CEO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of CFO pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.